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SURGERY

tology in the Diagnosis of Cancer

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til recent years pathologists have based cancer diagnosis on the general histological n of a tissue section, and the main criterion h a diagnosis has been the invasion of sur- ng tissues by neoplastic cells. It has ally been realized, however, that individual r groups of cells from a malignant neoplasm themselves possess characteristics which them in a class apart from their innocent s, and enable them to be recognized for they are solely on their own appearances, it reference to tissue pattern.

s has been a revolutionary step forward, t me emphasize that it has not come upon a sudden like a thunderclap. It has been a slowly unfolding process, although in the ecade the pace has increased at a tremen- ate. Although I do not intend to go into nged discussion of the history of the recog- of the cytological changes in cancer cells, nteresting to note that a paper on the sub- peared as long ago as 1887.

e great practical application of the recogni- f individual cancer cells has been in the sis of cancer by means of smears prepared arious bodily secretions and excretions and luid accumulating in body cavities. Diag- of cancer by this method has been applied er of the uterus, using cervical and vaginal , cancer of the lung, by the examination of n, bronchial secretions, or washings, cancer stomach by examination of gastric wash- ancer of the urinary system by examination ary deposits, and cancer of the prostate by nation of urine or of secretion obtained by ic massage. In addition, examination of l and ascitic fluids may assist in establishing nosis of cancer. Of the various possibilities ned perhaps the most fascinating and accu- s the use of cytological methods in the sis of uterine malignancy. Since my own ence has been concentrated to a great on this particular phase of the subject I e to deal with it in greater detail than the

nted at the Annual Meeting of the Manitoba Association, October 4th, 1950.

Apart from the methods of preparation of smears, the detailed technique of methods used in the preparation of material for microscopical examination does not lie within the scope of this paper. It should be noted, however, that some workers prefer to examine smears of material stained by Papanicolaou's technique or a variant of it, while others prefer to block material in paraffin and then cut and stain sections just as in ordinary histological preparations. Personally I have found the smear technique to be the most satisfactory and now use it almost exclusively.

The recognition and study of individual cancer cells is of great interest and importance from a purely academic point of view, but the most important practical application of the method lies in the fact that by employing it an earlier diagnosis of cancer may be made in many instances where other diagnostic methods would have failed. Any method which may lead to earlier cancer diagnosis demands our most careful consideration, since in the present state of knowledge early diagnosis is one of the cornerstones, if not the cornerstone, in the successful treatment of the disease.

In considering the cytological diagnosis of cancer there are certain general points to be borne in mind, since they apply with equal force to any case in which the method is being employed. Firstly, the presence of malignant cells in smears depends upon the exfoliative property of the growth, and if cells are not being shed they will not be found. Secondly, malignant cells may undergo rapid autolysis once shed, and it is essential that material be prepared in a proper fashion before sending it to the laboratory. Thirdly, a positive cytological report should always be confirmed wherever possible by a thorough histological study. Arising out of the first two points is a statement which cannot be repeated too often, namely, that a negative cytological report does not necessarily rule out the possibility of cancer.

I will now deal with each region in more detail, commencing with uterine cancer. As I mentioned earlier, this is the field in which I have had the most experience, and perhaps because of that fact, the field in which I have had results comparable to other workers.

Two main forms of uterine cancer exist, carcinoma of the cervix and carcinoma of the uterine body, and both are extremely suitable for cytological study since they are both highly exfoliative types of growth. Papanicolaou was

the first to call attention to the possibilty of using vaginal smears in the diagnosis of this type of malignancy, and it is interesting to note that his first paper on the subject appeared as long ago as 1928. This first paper passed by virtually unnoticed, and it was not until his second, in 1941, that the profession began to realize the potentialities of this new diagnostic method.

Various methods may be used in obtaining material from the cervix and uterine body. Originally material from the vaginal pool was aspirated by means of a pipette and smears prepared from this aspirate. This method has the disadvantage that any cells present may be greatly diluted, and other methods are now available which ensure a good concentration of cells. A very satisfactory method is that devised by Ayre of Montreal. In this, a specially designed wooden spatula is placed against the cervical os, and by a twisting movement is made to scrape the epithelial surface. This causes a quantity of mucoid material to adhere to the spatula, and within this mucus are large numbers of cervical cells. Smears are prepared from the material on the spatula. This method has been referred to as the "surface biopsy technique," since several layers of cells may be scraped off the cervix. It has one great drawback, and that is that whilst it is ideal for the diagnosis of epidermoid cervical carcinoma, which almost invariably arises at the squamo-columnar junction, it is by no means ideal in the diagnosis of endometrial cancer, since only little material from the cervical canal may get on the spatula. To make sure that uterine secretion is obtained it is advisable to supplement the surface biopsy technique by aspiration of material from the os by means of a pipette and to prepare a second smear from this material. By this means the chances of missing an adenocarcinoma of the endo-cervix or of the uterine body are greatly reduced. It is of the utmost importance to properly preserve the smears once they have been made, and this is done by immersing them before they are dry, in a mixture of equal parts of ether and 95 per cent alcohol. The minimum period of fixation is 15 minutes, but longer fixation does not harm. Following fixation, if the slides have to be sent to a laboratory, they may be preserved by putting a drop of glycerine on the smear, and then pressing a second slide on top. Again, the glycerine must be applied while the smear is still moist with fixative. I have emphasized these methods of preparation because so much depends on the initial work. An improperly fixed smear may mislead the pathologist and bring the method into disrepute.

What can we expect as regards accuracy of diagnosis? In obvious clinical carcinoma of the cervix, smears are 100 per cent positive. This, of course, is of purely academic interest, since in such cases the smear does not help in diagnosis. However, cytologists do like to such smears since they can keep themselves familiar with the grossly abnormal cell that such tumors produce.

The real fascination and help of the m lies in its application to cases of cervical carc in which the organ may appear to be only e or indeed normal on clinical examination these cases one can expect a 94 to 98 per accuracy in positive cases as judged by subse histological examination. The following c an example of an apparent erosion which p otherwise. The patient, a 37-year-old w complained of a vaginal discharge. On exa tion she appeared to have a cervical erosion atypical cells suggestive of malignancy were in the cervical smears. Serial sections th the amputated cervix showed the features pre-invasive carcinoma.

The next case is that of a physician's aged 49, who had a normal appearing c Cervical smears showed atypical cells, and strength of this a vaginal hysterectomy was ca out. Serial sections through the cervix sh intra epithelial carcinomatous change in squamous epithelium, with one area in break-through had apparently occurred, so this case was regarded as an early invasive dermoid carcinoma. This type of case, in the cervix appears normal on clinical exam tion, and yet is the seat of an early carcin represents a triumph of cytological diagnosis they are comparatively rare. Looking th my material for the past two years I find there have been five such cases, five out of 4,000 uterine smears which I have examine that period, and these 4,000 were selected to extent since the majority were from patients sulting a gynaecologist for one reason or an

The early type of carcinoma raises the question of the so-called pre-invasive or i epithelial carcinoma. There has been much ference of opinion on the subject, but the now general agreement that such an entity exist. Pund has stated that it may take as as six years for such a carcinoma to pro from its inception to a stage of invasion. cases offer an opportunity to treat cancer really early phase so that it can be compl eradicated. It is indeed fortunate that the cel foliated from such early neoplasms are sta indelibly with the malignant mark. It is impo to realize that when a positive smear repo returned in a patient who has a normal appe cervix, that the whole of the squamo-colu junction should be biopsied so that the patho may cut serial sections of the entire region. is essential since the abnormal area may be

ed to one very small part of the tissue. Ayre s described a cervical cone knife which enables s procedure to be carried out with a minimum trouble. I must confess here that this method not used in Halifax. The gynaecologists there me that they have now got vaginal hysterec- ny down to such a fine art that their mortality e in that operation is no greater than it would for an amputation of cervix or extensive psy. So that, if a positive smear report is re- ved on a normal appearing cervix a hysterec- ny is done, and it may be noted that in these y early carcinomas, removal of the diseased an is probably the most satisfactory form of atment.

The occasional false positive report occurs, but se tend to become less and less as the cytol- st gains experience.

Turning now to endometrial carcinoma, it has n my experience that the results obtained are no means as good. Maybe I am at fault, but figures cannot approach those of some authors, o claim a 90 per cent accuracy in proven nocarcinoma of the uterine body. I have only ched a 65 per cent accuracy; not a very good ure. It is well recognized that the cells from an nocarcinoma of the endometrium are more dif- ult to recognize as malignant cells than are se from an epidermoid cervical carcinoma, and addition there is less chance of picking these ls up in the smear material unless a pipette is d to aspirate material from the cervical canal. has been my experience too, that endometrial lyps will often give rise to odd-looking cells ich may be interpreted as malignant.

Occasionally malignant cells from an ovarian plasm may be found in cervical smears. I ently reported positive smears from two tients in whom subsequent operation showed ateral papillary adenocarcinomas of the ovary, t such cases are curiosities.

Apart from diagnosis, smears may also be use- following treatment of a cervical carcinoma th radiation. Under these circumstances certain tinctive radiation changes may appear in the lignant cells. These changes begin around the th day following the first radiation treatment d are usually maximal by the twelfth to fifteenth ys. This fact is of use in judging the response any particular growth to radiation therapy, ce if the malignant cells show little change then cancer is not likely to be very radio-sensitive, ilst if there are marked radiation changes in cells then the tumor is likely to be sensitive. this way the smears may be of some prognostic lue. Smears may also be of great value in low-up studies of cervical carcinoma, since lignant cells may re-appear before there is any ticeable clinical recurrence of growth and this phase of the work is of great help to the gynaecologist.

Some enthusiastic supporters of the smear technique have advocated that all women over the age of thirty should have tests carried out every year, but for many obvious reasons this is an impossibility. If the laboratory is not to be overwhelmed with smears, some kind of compromise has to be worked out. In Halifax it is now a routine procedure on any female coming to the gynaecological clinic, and the majority of the gynaecologists take smears routinely on their private practice patients. My personal view is that every female who has a pelvic examination performed should have smears taken just before the vaginal examination is carried out. If this is done at least a few of the extremely early cancer cases will be detected.

Much has recently been written on the diagnosis of bronchial carcinoma by means of sputum or bronchial smear examination, and some workers have claimed excellent results. My experience has not been extensive in this field, although all bronchial secretion received in the Halifax laboratory is now examined for malignant cells as a routine procedure. On a small series of cases my results cannot compare with the 90 per cent accuracy reported by some workers. However, one does on occasion find malignant cells in sputum from lungs which clinically show no sign of malignant disease, and the method is of undoubted value. My own results are possibly due to the fact that I have deliberately discouraged sputum examinations, knowing only too well that once started there would be no holding the avalanche, and that the laboratory would be overwhelmed.

As in the case of vaginal smears, it is essential that sputum and bronchial secretion be prepared properly before staining. The fresher the material the better, and it is best to prepare smears in exactly the same way as outlined for vaginal smears, as soon as the sputum is coughed up, or immediately the secretion is removed via the bronchoscope.

One point should be emphasized and that is that it may be necessary to examine several specimens on succeeding days in order to find tumor cells in positive cases, just as in tuberculosis of the lungs multiple specimens may have to be examined before tubercle bacilli are found.

There is no doubt that sputum examination may be of the greatest value in the diagnosis of lung carcinoma, and again one is faced with the problem of how to employ it, should every patient coming into hospital have a routine test done, or should it only be applied to selected cases. Once again the limitation is imposed by the capacity of the laboratory and the availability of trained personnel, and in an average sized hospital routine

sputum examinations might easily swamp the laboratory.

The examination of gastric contents for the presence of malignant cells is gradually gaining recognition. In this instance it is, of course, essential that the material be absolutely fresh, since cells rapidly undergo degenerative changes in the stomach contents. Material is best obtained by washing out a fasting stomach and mixing the washings so obtained with 95% alcohol immediately on withdrawal. This mixture is then centrifuged, and smears prepared from the sediment, followed by fixation and staining as detailed above. One often finds that the cellular content in these smears is very low, and searching them can be a tiresome procedure. In my experience too, gastric carcinomas do not appear to be as exfoliative as some of the other tumors mentioned, and in many cases only an occasional atypical cell can be found. Papanicolaou has recently described a method whereby mechanical irritation of the gastric mucosa is employed in an attempt to rub off fresh cells. Briefly this consists of a small rubber balloon (consisting of a condom) to which about 250 pieces of silk are attached. By means of tubing this balloon can be inflated in the stomach and on withdrawing it any adherent material is washed off, mixed with alcohol, spun down and smears prepared from the deposit. The method shows considerable promise, as fresh cells in large numbers are rubbed off the gastric mucosa especially when malignancy is present, since a normal gastric mucosa apparently resists mechanical irritation.

For reasons mentioned earlier I have had little experience of the examination of urine for the presence of malignant cells in urinary tract or prostatic cancer, or of prostatic secretion for prostatic carcinoma. These methods are being written about on an increasing scale, but the results, though encouraging, leave a great deal to be desired. This is understandable when one considers the pathology of malignant tumors of this region, since many renal and prostatic growths may not come into direct contact with the urinary stream.

The remarks which I have made earlier on the employment of this technique apply with equal force in the case of gastric washings, urine and prostatic secretion. The limiting factor in the number of examinations is the laboratory.

Malignant cells can usually be demonstrated in pleural or peritoneal fluids when metastatic lesions are affecting the pleura or peritoneum. Occasionally such an examination is of great value in the diagnosis of an obscure exudate. In Halifax a Papanicolaou stained smear is done as a routine on all pleural and peritoneal fluids and the results are very encouraging. Providing that the malignancy is actually invading the lining membrane, malignant cells are invariably prese centrifuged deposits of the fluid.

In conclusion I wish to make a few re on the impact of this diagnostic advance o laboratory services. If any real benefit is obtained from the method then inevitably mendous number of additional specimens have to be examined by the laboratory, an number in a very short space of time run thousands annually. The preparation of the terial for examination demands care and time, but by far the most time-consuming p the technique is the reading of the prepared Frankly positive smears may only require a of minutes search before undoubtedly mali cells are seen, but these are usually in the min and most slides will require a much longer period. Most workers are agreed that no should be reported as negative until a prol search has been made, and the minimum suggested is 15 minutes. All this means tha pathologist is faced with work which will up a large proportion of his time, and unle is wary he may find himself a full time cytol Few of us are willing to give up our other in order to examine a long procession of sm indeed I doubt whether our eyes would stan to the strain. If smears are to be done on a scale the pathologist must be shielded fro main bulk of the routine normals, and in to do this "screeners" must be trained. Fortun technicians can be trained so that they can out the abnormal smears for reference to pathologists, but the period of training is three to six months.

This is the only way to make good use method. So far I have not been able to he screening system, and all smears in Halifa examined personally by myself. From my ea remarks you can see that the effect of thi been to severely curtail the variety of speci examined, simply because the volume of would otherwise be overwhelming.

Cytology in the diagnosis of cancer is a valuable advance in the diagnosis of this di but in order to obtain the best results fr personnel must be trained and additional made available to departments of pathology even so it is extremely unlikely that a r examination of the population as a whole at lar intervals will become a practical propo in the foreseeable future, owing to the nu of personnel that would be required to carr the test.

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MEDICINE

Cerebral Vascular Accidents Their Diagnosis and Treatment*

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Probably nowhere does the physician feel so lpless and so small in the imploring eyes of the aiting relatives as when confronted with a tient hemiplegic or unconscious, or both, who as a few moments before a healthy, active tizen.

As with any problem one must approach the uation with an orderly classification of the riants. No problem of such complexity is classi-d as simply as the cerebral vascular accidents. here are but two main types of lesions; those le to infarction and those due to haemorrhage.

An infarction may be due to embolism, throm-sis or perhaps spasm.

Haemorrhage is of two types, intra-cerebral d sub-arachnoid. Not uncommonly both occur gether as an intra-cerebral haemorrhage may pture into a ventricle or through the cortex. nversely a primary sub-arachnoid haemorrhage ay burrow deeply into the cerebral substance.

There is no certain clinical differential be-een a cerebral infarction and an intra-cerebral emorrhage. Either may be steadily or inter-ittently progressive or may be abrupt. Either ay be massive or slight. Either may come on in eep or in agitation, either may show fairly rapid provement.

Help may be found in accurate localization. early all cortical lesions are thrombotic, nearly l capsular and basal ganglia lesions are haemor-agic.

Infarction

With an obvious source such as endocarditis, a rebral vascular accident may properly be as-med due to embolism. Whether spasm actually oduces cerebral symptoms is still open to ques-n. There is very scanty muscularis in the edia of the cerebral vessels. A thrombosis may venous producing a red infarct or arterial, oducing a white infarct.

There is another group of very definite syn-omes which if recognized can be labelled with rtainty as thromboses. These are the syndromes the brain stem arteries of which the posterior ferior cerebellar is by far the most common. hese syndromes are in standard texts of neur-ogy and need not be repeated here.

In general it may be said that if the neurologic cture is out of all proportion to the amount of intracranial distortion visualized, then the condition is not surgical and is probably thrombotic. (Case 1).

Having once decided that a lesion is infarction the treatment is legion. As usual this means there is no really effectual therapy. Stellate block has many capable advocates[11]. Anti-coagulants should never be used without first examining the spinal fluid for blood. Whether one prescribes nicotinic acid or whiskey as a vasodilator matters little, at least clinically.

No matter what ones initial impression and method of treatment may be he should follow three dictums. First determine and record as nearly as possible the exact location and extent of damage at the first visit. Secondly, observe in the follow up period whether the condition improves, stays the same or progresses. Thirdly, observe whether subsequent attacks indicate involment of the same region. For instance, a man may have several episodes consisting of transient aphasia, then an episode of aphasia and weakness of the right hand. In any such case that does not improve, or that progresses or that repeats in adjacent areas, one must entertain the possibility of an expanding lesion.

The differential diagnosis between a vascular accident and a brain tumor even yet taxes the ingenuity of the master neurologist.

If a visual field defect is present it may not only localize the lesion but may indicate whether it is vascular or new growth. The vascular lesions tend to give a precipitous slope between the isopters for enlarging targets. The slope for a tumor is more gentle.

"Patients may be admitted to a hospital repeatedly before they come in with a hemiplegia which remains. It is especially noteworthy that weeks or months may thus pass sometimes with incomplete recovery between attacks before the thrombosis becomes permanent[12]." It is also especially noteworthy that some of these at a later date turn out to be brain tumors. It is better to investigate ten vascular accidents for an expanding lesion than to bury one meningioma as repeated vascular accidents. (Case 2).

Intra-cerebral Haemorrhage

The rapid fulminating intracerebral haemorrhages offer little opportunity for therapy of any type. On those surviving long enough attempts have been made to evacuate the clot and stop the bleeding with occasional success[15]. This probably will be done more frequently in the future. It must be remembered, however, that whatever cerebral tissue is destroyed by the haemorrhage

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and whatever is destroyed by the surgeon for exposure will remain destroyed.

The less vigorous haemorrhages offer more opportunity for relief. These usually stop spontaneously and the residual clot may behave much as a tumor would. Removal of the clot and coagulation of the bleeding points may give considerable relief. (Case 3).

Spontaneous Sub-arachnoid Haemorrhage

Less than 10% of the spontaneous sub-arachnoid haemorrhages are caused by tumors[3], hemangiomata, blood dyscrasias, metastases, intracerebral haemorrhages that burst through, arteriovenous aneurysms, etc. (Case 4). Over 90% are caused by leakage from a congenital aneurysm of the berry or saccular type. These devastating haemorrhages occur usually in young people occasionally preceded by minor warnings of simple headache or migraine.

The mortality rate in large series is exceedingly high. From one-third to one-half die in a first attack. About the same proportion of the survivors will succumb in the well nigh inevitable following attacks. Many of the final survivors are neurologic cripples[5, 10].

Whether these aneurysms result from developmental weaknesses in the muscle walls at bifurcations or from unresolved vestigial remains of a normal primitive vascular tree[1] matters little clinically. It is important that over half of them occur anteriorly about the circle of Willis where surgical approach is comparatively easy[2, 9].

These aneurysms may usually be visualized by carotid angiography occasionally supplemented by air encephalogram or ventriculogram. (Cases 5, 6 and 7).

Once visualized the advisability of following conservative or radical methods of treatment may be decided. It will always be a difficult decision involving such intangibles as the individual's mathematical probability of survival and the probable results of clipping the necessary vessels to trap or remove the aneurysm. It must be remembered that frequently these aneurysms are multiple. Loss of consciousness, vomiting and convulsions are all very unfavorable prognostic features[8].

Conservative treatment consists in supportive methods in general, symptomatic relief, and one of two regimes of draining the body fluids. Some believe in daily drainage of the bloody cerebrospinal fluid with lowering of the pressure. Others feel it is better to leave the hydro-static tamponade of the cerebrospinal fluid at as high a pressure as tolerated and if anything lower the arterial pressure during the acute attack with phlebotomy.

There are no large series to support either regime nor have mortality rates appeared on any large series of aneurysm surgery. However, the mortality in capable hands does not approa[illegible] mortality of the untreated disease[2, 10, 13].

The minimal investigation of these intrac[illegible] vascular accidents consists of a localizing [illegible] logic examination, skull rays, and a ca[illegible] lumbar puncture without Queckenstedt.

Further investigation consisting of e[illegible] encephalogram[4, 16] air-encephalogram, and/[illegible] giography performed as early as possible, is[illegible] cated in the following:

1. The cerebral vascular accident in any [illegible] who appears to the practitioner as too you[illegible] have a "stroke."

2. Any cerebral vascular accident with[illegible] sub-arachnoid blood.

3. Any repetitive stroke which on neur[illegible] examination indicates injury to adjacent ar[illegible] even to one hemisphere.

4. Any cerebral vascular accident which[illegible] a period of months progresses rather than re[illegible] stationary or improves.

It is not supposed that absolute indicatio[illegible] operative interference in the cerebral va[illegible] accidents can be set forth now or perha[illegible] Each case must be decided as it develops. [illegible] proposed that further investigative procedur[illegible] indicated in certain groups of cerebral va[illegible] accidents. With accurate visualization o[illegible] lesion one may more intelligently plan his[illegible] paign.

In summary, the cerebral vascular acc[illegible] are herein briefly categorized with illust[illegible] case reports. They present a very knotty pr[illegible] in diagnosis and therapy. Certain types w[illegible] neuro-surgical investigation. Some can be [illegible] fited by operative interference.

Case Reports

Case 1—M. G., female, age 70. Refer[illegible] Dr. L. Cherniak, Winnipeg, and Dr. W. I. [illegible] Selkirk. Four episodes of loss of consci[illegible] lasting several days and apparent comple[illegible] covery, 2-3 month intervals.

Admitted comatose, stertorous respir[illegible] Spastic on left, flaccid on right. Bi[illegible] papilloedema, 1 diopter. Ventriculogram re[illegible] a minimum shift to the right with slight dist[illegible] of the left temporal horn and lateral ven[illegible] An example of minimal intracranial dist[illegible] with maximal neurologic deficit. Operati[illegible] July 10, 1950, revealed only softened brain [illegible] region of the distortion. Autopsy 7 days [illegible] revealed huge bilateral low fronto-temporal s[illegible] ings, presumably due to thrombosis.

Case 2—J. K., male, age 30. Referred [illegible] H. L. C. Garner, Moose Jaw. A 1-year h[illegible] consisting solely of transient episodes of in[illegible] to phonate. Then came an episode associate[illegible] numbness of face. Angiogram revealed a sp[illegible] area of increased vascularity suggestive

ngioma. At operation, April 8, 1950, this removed from the lower left frontal region.

se 3—O. R., male, age 51. Referred by Dr. ey Davidson, Lundar. A known hypertensive evidence of a space occupying lesion in the parieto-temporal region; loss of strength in ght hand and leg, a slight agnosia, visual and e, and a marked aphasia. The differential osis was between a brain tumor and a cere- vascular accident. At ventriculography the eedle encountered a few cc. of bloody fluid. was replaced by oxygen and the subsequent genograms revealed the outline of a cavity ining a solid mass. At operation, June 16, this proved to be a large intra-cerebral clot e left parietal region. The man made a ed recovery from his cerebral symptoms.

se 4—C. A., male, age 21. Referred by Dr. ulson, Lundar. Rapid onset left hemiplegia, anaesthesia, and hemianopsia. Headache iff neck. Bloody cerebrospinal fluid. Angio- Feb. 9, 1950, revealed an arterio-venous fis- pparently from anterior choroidal to internal al veins, then to vein of Galen and straight

se 5—A. S., female, age 36. A sudden blind- eadache and collapse. No localizing neuro- signs. Skull plates normal. Gross blood in rebro-spinal fluid.

giogram June 6, 1950, revealed aneurysm of sterior communicating artery. While in hos- mproved slightly but on the 14th day became dly worse and died three hours later. Opera- as refused until terminally when there was sly no hope.

se 6—S. P., male, age 21. Referred by Dr. J. mmon, Red Lake. Two or three warning s of mild headache, then an attack that ren- him unconscious for several hours. He was ht into the hospital in a state of irritable iness and no lateralizing signs but he ally developed a right hemiplegia. Angio- revealed only evidence of ventricular dilata- Ventriculogram revealed a bulge into the of the anterior horn on the left. At opera- Aug. 5, 1950, the chiasmal region was free od. The anterior horn was then approached ortically and the bulge seen to consist of soft dark clot which led to the bifurcation of the anterior and middle cerebral arteries. Although no sac could be identified as such there was vigorous bleeding from the crotch necessitating the placing of clips on the carotid and both branches. The patient has remained hemiplegic and partially aphasic, but is recovering speech. He is otherwise well, alert, and free of headaches.

Case 7—W. M., male age 49. Diagnosed and referred by Drs. R. G. Greer and F. G. Allison, Winnipeg. Eight days earlier while putting up awnings sudden severe head pain, nausea, collapsed before able to walk ten steps. Bloody cerebrospinal fluid.

Angiogram—Aneurysm at or near bifurcation of anterior and middle cerebral on right. Encephalogram—Mass in same region. Right frontal craniotomy—Aneurysm burst as exposed. All entering vessels clipped. Two months later patient entirely well and back at work.

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ANAESTHESIOLOGY

Western Canadian Anaesthetist's Society Annual Meeting Calgary, February 21-24

The program is not complete at this time, but will include a well known Anaesthetist from the United States, as guest speaker. Round table discussions and clinical demonstrations are also planned. Social activities will be typical of Western Canadian hospitality.

Will those who plan on attending this convention contact either Dr. B. Roe, Children's Hospital, Winnipeg, or Dr. R. T. Douglas, Calgary Clinic, Calgary, Alberta.

Abstract

Position of the Anaesthesiologist on the Hospital Staff*

Harold R. Griffith, M.D., F.I.C.A., Montreal, Canada

Associate Professor of Anaesthesia, McGill University

Author brings to the fore his firm resolve and that of all anaesthesiologists to discover a remedy for the lowered prestige of Anaesthesiology and of those who administer anaesthetics, compared with other specialties of medical practice and of those who practice them. He states that this is especially the case in some American and Canadian Hospitals. Lortie[1] has pointed out the following reasons for this state of affairs. (1) The still widely held concept that anaesthesia is "nurses' work," (2) Subordination of anaesthesia staffs to hospital administrators and profit seeking hospital policy, (3) The dominant position of the surgeon on hospital staffs. He states that for more than a generation surgeons have dominated medical boards, have set up scales of remuneration greatly in their favour, and have dictated to professional colleagues in other branches not only how much these colleagues should be paid, but oftimes how they should carry on their work.

(4) A relative non-recruitment of forceful ambitious young doctors for anaesthesiology because of this lowered status, thus maintaining the vicious circle.

The author states that it must be the aim of all anaesthetists, in fact their bounden duty, to work towards greater recognition of their specialty and equal status with those practicing other specialties.

An ideal position for the anaesthesiologists on the hospital staff is outlined by the author as follows:

(1) Anaesthesiology should be establishe separate hospital department and not as a department of surgery.

(2) The director of the department and her principal assistants should be certifie cialists in anaesthesiology.

(3) Appointments to the staff should be in the same manner as is the custom for members of the attending staff and all a thesiologists should be active members Medical Staff. The director of the depar should be a member of the Medical Boa Executive Committee of the Medical Staff should have the same status as the chiefs of departments.

(4) The income of anaesthesiologists shou comparable with that of other specialists equal qualifications and seniority. Whethe muneration is by salary or by fee for service depend on conditions in individual hospital it should be arranged that anaesthesiologists knowledge of the exact revenue and expens their department. The Department of A thesiology should aim to be self-supporting should not be expected to make a greater tribution toward the hospital deficit than is by the doctors of other departments. A par ship or group plan is proving to be a most factory system of anaesthesia practice.

(5) There should be mutual respect, sym and understanding between all professional leagues of course, and anaesthesiologists sh as a minimum, be responsible for proper preparation of the patient, maintenance of as his normal physiological function as possible ing operation, and for the immediate post-oper recovery period. Confidence between the a thesiologist, surgeon, obstetrician and others cerned will soon establish the necessary operation.

(6) Teaching of anaesthesiology should be stant even in small hospitals.

To achieve this ideal the author has made eral practical suggestions for action by a thetists themselves and by the medical profe as a whole:

(a) Qualities of firmness but combined w large measure of tact, enthusiasm, tolerance, dom and Christian charity, should be the a the anaesthesiologist in his personality. A ce failure is the young man who is over-confi aggressive, combative and mercenary.

(b) The ability and determination to pr high quality of anaesthesia service is of a prime requisite. To establish prestige for new specialty we must demonstrate both the

* From Volume 29, Number 4, July - August, 1950, of Current Researches in Anaesthesia and Analgesia.

our work and also the fact that we do it far tter than any non-specialist.

(c) The anaesthesiologist should make himself asset to the hospital by his readiness to look r and take opportunities of service outside his ecialty. Such fields might be readiness to rve on committees, and acceptance of assign-ents of all kinds unpopular with others; to be iendly with all with whom one works in the spital and especially with those who are not sy to be friendly with and those who we con-der are not up to our standard of efficiency. ch comparatively recent additons to medical tivities as oxygen therapy, blood transfusion, travenous therapy, bronchoscopy, emergency eatment for poisoning and coma, diagnostic and erapeutic nerve blocks, are neglected in many spitals because there is no physician on the staff ith the interest and skill needed for proper super-sion over such a variety of service. The anaes-esiologist may be just the one who is specially alified to take over any or all of these "odd bs." An anaesthetist might possibly help with dministration of a hospital, especially the small ne.

Finally, the author emphasizes the words of e report of the Hess Committee on Hospitals and e Practice of Medicine of the American Medical ssociation[2]. It is now the official policy of the merican Medical Association "that it is illegal . . and unethical for any lay corporation to prac-ce medicine and to furnish medical services for professional fee, which shall be so divided as to roduce profit for a lay employer, either individual institutional, including hospitals and medical hools."

"The American Medical Association may ithdraw its recognition from hospitals which continue to exploit doctors, including anaes-thesiologists." However, the report states that: "There can be no exploitation of the doctor or of the hospital if everyone concerned in both management and on the professional staff will work together to supply the greatest possible good quality medical and hospital services to the public and that most matters in dispute can be settled at a local level by joint action. . . . Every professional man on the appointed staff would have a voice in the professional management of the institution. The pathologist, radiologist, anaesthesiologist and psychiatrist should have equal standing with other staff members as active members of the staff."

The author concludes that all this adds up to the fact that at last the forces of organized medicine are aligned to come to the assistance of professional colleagues in our specialty who may be the victims of unfair economic discrimination. Well planned, tactful but firm action of local groups of anaesthesiologists can be very effective in improving local conditions, backed up by national Anaesthesia organizations. He states that since our services are vital to hospitals, to surgeons, and to the public, and the demand is far greater than the supply, we are in a stronger bargaining position than we realize, provided we will only stand together and if we are honest and ethical we can look forward to better days for anaesthesiology.

Victor A. Rogers, M.B., Ch.B.,
Anaesthesiology Dept.
Winnipeg Gen. Hosp.

References

1. Lortie, D. C. — "Doctors Without Patients: the Anaesthesiologist — A new Specialist." Unpublished Dissertation, University of Chicago, 1949.
2. Report of Committee on Hospital and the Practice of Medicine. J.A.M.A., July 2, 1949.

A FIVE POINT ATTACK...

... on bronchial asthma

PENTOBARBITAL

Sedation of the Central Nervous System.

EPHEDRINE

Stimulation of the Sympathetic Endings.

LEVO-HYOSCYAMINE

Inhibition of the Parasympathetic (Vagus) Endings.

THEOPHYLLINE

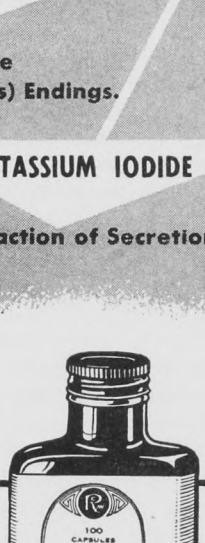
Relaxation by Direct Action on Bronchial Muscle.

POTASSIUM IODIDE

Liquefaction of Secretions.

BETHIODYL

Will



1. Sedation of the Central Nervous System.
2. Stimulation of the Sympathetic Endings.
3. Inhibition of the Parasympathetic (Vagus) Endings.
4. Relaxation by Direct Action on Bronchial Muscle.
5. Liquefaction of Secretions.

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General Practitioners

General Practitioners' Association of Manitoba
In Affiliation with the Manitoba Medical Association

Message To All General Practitioners

Do you belong to the "General Practitioners' ociation?" Perhaps you don't. You may ask, hy should I?" Here's why:

This recent organization was formed for your efit and has already helped you considerably, ıough perhaps you do not realize it. It has wn to the attention of the Canadian Medical ociation that the General Practitioners are the kbone of our plans to care for the people of this ntry. The C.M.A. has recognized this fact and now helping to advance and finance a new ion, namely, The General Practitioners' Sec- of the Canadian Medical Association.

Locally, we are a Section of the Manitoba Medi- Association. We hope to be of value to that anization, and expect that, in turn, they will) us, so that our standards of proficiency will ome and remain as high as possible. Only in manner will we be able to retain as a privilege a right our present status of caring for our ents as we deem fit, either in the home or the pital, whether it be surgical, medical, or any er branch of medicine.

General Practitioners of the United States have ned a powerful organization called "The demy of General Practice." They do not intend oussyfoot. Members must conform to certain dards of post-graduate study each year in er to get the recognition and backing of the demy. Those who do not do so will regress, be denied many of today's privileges, and ıtually attain the status of a "First-Aid Man," ı a corresponding lowering of position in the munity and a necessarily lower income.

We must make the profession as a whole, but icularly the general public, realize that we competent to take care of our charges. But , we must make sure that we are competent. G.P. Section of the C.M.A. is at present study- ways and means of accomplishing this great . It needs your help, and you certainly need nelp.

What can you do?

. Join the General Practitioners' Association Manitoba.

. Attend meetings to the very best of your ity.

. Give as much help as you possibly can when ed.

. Send your fee ($5.00) to the Treasurer, Dr. A. Keenberg, 901 Boyd Building, Winnipeg.

We Need Sufficient Funds to Function Adequately

We are committed to two annual Scholarships of $150.00 each for two internes who intend to engage in General Practice.

Do you realize that, through the efforts of our Manitoba G.P. Association, you now receive $25.00 more for each appendectomy done through M.M.S.? Other procedures have likewise brought you increased revenues.

We will help you. You help us. See you at the meetings.

M. M. Brown, M.D., President.

Executive Meeting, December 19, 1950

Chairman: Dr. M. M. Brown.

In attendance: Dr. Jack McKenty, Dr. J. Roy Martin, Dr. A. A. Keenberg, Dr. Glen Hamilton, Dr. Q. Jacks, Dr. L. A. Sigurdson.

The meeting was called to order by Dr. M. M. Brown, newly elected President, at 8.45 p.m.

The Secretary read the report of the Sub-committee on General Practice.

Resolution

Moved by Dr. A. A. Keenberg, seconded by Dr. Glen Hamilton, that certification of G. P.'s be discussed at a general meeting. Carried.

For the information of the Executive, the Secretary outlined some of the more important business transacted at a meeting of the Manitoba Medical Association Executive on Sunday, Dec. 17, at the Medical Arts Club Room.

The question of Committees was left for a future date.

A letter from Dr. A. T. Gowron was read and tabled but out of that a discussion occurred where it was suggested that all groups should submit a schedule of fees to the Manitoba Medical Service once annually, preferably in the fall.

It was suggested that for our guest speaker, the Honorable Ivan Schultz be asked to address the Association either at a general meeting or at a meeting of the Winnipeg Medical Society.

It was suggested that the fees for membership remain at $5.00.

Resolution

Moved by Dr. McKenty, seconded by Dr. Jacks, that the minutes of the executive and general meetings be furnished to the Editor of the Manitoba Medical Review by the Recording Secretary. Carried.

The President stated that the monthly executive meetings would be held at Dr. Keenberg's office

on the second Tuesday of each month for 1951.

The date of the next general meeting was fixed for Friday, February 2, 1951, and the Secretary was instructed to send notification to the members and also to post notices in the hospitals.

Report of Sub-Committee on General Practice

Mr. Chairman and Gentlemen:

I beg to submit the following interim report of the Sub-committee on General Practice.

At your last meeting, which was in Halifax, you set up this sub-committee and made available $1,000.00 to the Dominion Section of General Practice to use as it saw fit. These actions were much appreciated by this Section, and were taken as evidence of your understanding of some of our problems and of a desire to assist us in solving them. During two full days' discussion and study, the Section of General Practice reached some conclusions which we believe are of some importance to organized medicine in this country.

It found that the problem of greatest immediate urgency was that of finding satisfactory plans for integrating the general practitioners into the staffs of the large city hospitals. We have taken as our chart or guide in this matter the "Proposed by-laws for medical staffs of intermediate hospitals" recently drawn up by a committee of the Ontario Medical Association. In principle they have our full support. We anticipate that these by-laws soon will have the approval of the Ontario Medical Association.

The second matter, and this is of much greater long range import, is the desirability of setting up standards of competence in general practice. A bit of history here is necessary. Last year the Section of General Practice asked Dr. G. G. Ferguson of Saskatoon to chair a committee to advise us as to the best method of proceeding to do this. In Halifax, Dr. Ferguson reported to us that there were two roads to this goal.

1. That certification might be made in academic subjects. To do this we would need a new incorporated certifying body or have one of the existing incorporated certifying bodies assume this new role.

2. Or a "certificate or acknowledgment of merit by fellow practitioners involving such points as proficiency in work, attendance at refresher courses or post-graduate studies, integrity and assumption of full professional and civic responsibility can best be done through an association of physicians. It might be possible that within the Section of General Practice an academy or council could be developed, membership in which would signify recognition as mentioned. Membership would also be noted by certificate and there is no limit to the value of such membership, which can be developed by the physicians themselves."

Dr. Ferguson cautioned us not to proceed either approach unless opinion had crystal very definitely. Our decision was made the latter method of approach.

We have approved of a Dominion Section General Practice that has three types of mem These are full members, associate member honorary members. Only full members ma in business meetings, or hold office. The doctors who have two years' internship and years in general practice or one year's inte and five years in general practice. They a quired to take 150 hours post-graduate study three-year period. They must be members Dominion and of their provincial and local m associations.

This is patterned after the regulations g ing membership in the American Acade General Practice. Some of us have dislik idea of dividing general practitioners in thi into two groups—the cream and the skimmed so to speak. However, we have come to th clusion that there is no other way by whi can make real progress in laying down stan of excellence that will serve to stimulate guide those within and without our ranks. this is only on paper. Much work is nec to implement these regulations of the Sectio only group with enough at stake to face t tailed work and the difficulties involved general practitioner group itself.

In order to help build a strong Section o eral Practice, and to learn what the general titioners were thinking, its executive reques as its Chairman to attend the various Div meetings. After consultation with several it was decided to ask Dr. A. D. Kelly to rep the Section in the Eastern provinces and that these provincial associations consider up committees on general practice with Chairmen our representatives on the Do Executive of the Section. Dr. E. C. Mc Vancouver attended the Divisional meeti Alberta and Saskatchewan. I attended th British Columbia and Manitoba.

Dr. McCoy and I feel that considerable pr was made by our attendance at these mee Much help and many useful suggestions were to us by members of various groups auch a cationalists and specialists. Probably a balanced view of these activities can be ob from your provincial representatives than me.

The Section of General Practice in sess Halifax directed that a meeting of the exe be held in mid-winter. To this end a meet planned for January 15th, 16th and probabl in the Royal York Hotel, Toronto. This m is to proceed with organizational problems as

ve. We expect to have with us a member of American Academy of General Practice to give he benefit of their experience.

To date probably more than half the funds you cated to us have been spent. We wish con- ration be given to assisting further to help pay travelling and maintenance expenses of the esentatives to the January meeting of the utive of the Section. There are two members his from Ontario, two from Quebec and one n each of the other provinces. There are four- in all. If they should all attend the cost ld be probably about $1,800.00 to $2,000.00.

Thus an additional sum of about $1,500.00, with t we have, would be required. We believe our activities are of sufficient importance to whole profession to warrant serious considera- being given this request.

W. V. Johnston, Chairman,
Sub-Committee of the Executive
Committee on General Practice.

Book Review

A new edition (the eleventh) of **Wheeler and r's "Handbook of Medicine"** has just been pub- ed. Since it first appeared nearly 200,000 es have been sold and, among our older ders, many will think, with gratitude, of the o it gave them in their student days. The new ion is up to date and remarkably compre- sive. Its convenient size (648 pages) and low e ($3.75) appeal to students while its concise- s and completeness appeal to busy men in ctice. It stresses the important points in logy, diagnosis and treatment, at the same time ng the essentials of pathology, etc. It is cially valuable for students because it focusses r attention on the things they must know. The sent edition has been completely revised by ert Coope of Liverpool. There is a number of grams, charts and photographic reproductions.

Wheeler and Jack—Handbook of Medicine, sed by Robert Coope, M.D., B.Sc., F.R.C.P., enth edition, 648 pages. Toronto: Macmillan npany of Canada. Price $3.75.

The Canadian Red Cross Blood Transfusion Service December, 1950

Name of Hospital:	Total Pts. Transfused	Total Bottles Used
Winnipeg General	262	479
St. Boniface	203	346½
Misericordia	72	127
Grace	92	132
Deer Lodge	45	117
Victoria	26	33
St. Joseph's	22	25
Concordia	15	24
Children's	29	21
Municipal Hospitals	8	11
St. Boniface San.	1	2
Selkirk General	22	26
Brandon General	30	34
Portage la Prairie	12	12
Others (20 Hospitals)	54	108
	895	1497½

Comments

During December there was a sudden rise in consumption of blood, bringing the total to 1,500 bottles, the previous monthly total usually being 1,200 to 1,300 bottles. Difficulties arose in meeting the demand because this unexpected rise in consumption came at a time when, as was anticipated, donors were a little less easy to obtain. I am writing this report in mid-January and we are only now getting ahead of the game. During this period of difficulty we have been compelled, most reluctantly, to request individual physicians and surgeons to diminish or delay requisitions of blood for their patients. This most distasteful duty has been made very much easier by the understanding and co-operation with which we have been met by the doctors concerned and I must record my gratitude to them.

Blood consumption in Winnipeg is steadily rising. To take the two largest general hospitals, the average monthly consumption during a representative three-month period early last year was for the Winnipeg General Hospital 423 bottles and for St. Boniface Hospital 248 bottles. A similar monthly average during the last three months of 1950 was for the Winnipeg General Hospital 467 bottles and for St. Boniface Hospital 317 bottles. Similar increases appear for almost every hospital we serve and this rise in consumption must be added to the needs of hospitals in the rest of Manitoba as they come within the scheme one by one. Finally, we will start servicing Fort William and Port Arthur in the near future. This will mean that at least 600 donors per week will have to be bled, instead of the current figure of 450 to 500.

Cecil Harris, B.Sc., M.D., M.R.C.P.,
Provincial Medical Director.

January, 1951.

University of Manitoba, Faculty of Medicine

REFRESHER COURSE PROGRAM

Arranged by the Committee on Post Graduate Studies

Winnipeg, March 26th, 27th, 28th, 29th, 30th 1951

Guest Speakers

Dr. Gaylord W. Anderson
Mayo Professor and Director of School of Public Health, University of Minnesota.
President-Elect, American Public Health Association.

Dr. Douglas E. Cannell
Professor of Obstetrics and Gynaecology, University of Toronto.

Dr. Ray F. Farquharson
Professor of Medicine, University of Toronto.

Dr. Walter C. MacKenzie
Professor of Surgery, University of Alberta.

Monday, March 26th

Morning

Health Officers' Association Program.

Registration for Refresher Course at Fort Garry Hotel.

Noon

12.30 **Luncheon — Fort Garry Hotel.**
Chairman—Dean L. G. Bell.
Guests—
Hon. Ivan Schultz, Minister of Health and Public Welfare.
President Gillson, University of Manitoba.
Speaker—Dr. Gaylord Anderson, University of Minnesota.

Afternoon

2.15 **Fort Garry Hotel.**
Chairman—Dr. F. G. McGuinness.

1. Obstetrical Topic:
Dr. Douglas E. Cannell, University of Toronto.

2. Management of the Menopause:
Round Table Conference.
Chairman—Dr. Elinor Black.

Tuesday, March 27th

Morning

St. Boniface Hospital.

9.00 **Clinical Program:**
X-ray Conference.
Management of Renal Disease.
Cough — as a Symptom.
Geriatric Topics.
Management of Diabetes.

Noon

12.15 **Luncheon, St. Boniface Hospital.**
Chairman—Dr. W. F. Abbott.
Speaker, Dr. Douglas E. Cannell, Professor of Obstetrics and Gynaecology, University of Toronto.

Afternoon

St. Boniface Hospital.
Chairman—Dr. D. S. McEwen.

2.15 **Hemorrhage in Obstetrical Practice:**
Dr. A. W. Andison.

Management of Thyroid Disease.
Round Table Conference.
Chairman—Dr. A. Hollenberg.

Wednesday, March 28th

orning

Winnipeg General Hospital.

.00 The Rational Use of Quinidine:
Dr. A. B. Houston.

Fatigue as a Symptom:
Dr. G. L. Adamson.

The Management of Anuria:
Dr. Ruben Cherniack.

The Sprue Syndrome, a Discussion of its Early Recognition:
Dr. D. L. Kippen.

.40 Surgical Topics:
Dr. C. W. Burns and Staff.

Noon

12.15 Luncheon, Winnipeg General Hospital.
Nurses' Residence.
Speaker—Dr. Ray Farquharson, Professor of Medicine, University of Toronto.
Diagnosis and Treatment of Anaemias.

Afternoon

Medical College — Theatre "A"
Chairman—Dr. C. W. Burns.

2.15 1. Palliation in Tumor Treatment:
Dr. Walter C. MacKenzie, University of Alberta.

2. ACTH and Cortisone in Clinical Medicine:
Round Table Conference.
Chairman—Dean L. G. Bell.

3. Colles Fracture — Illustrated by Film:
Dr. F. Robert Tucker.

Thursday, March 29th

Iorning

Deer Lodge Hospital.

9.00 Clinico-Pathological Conference:
Dr. J. D. Adamson, Dr. T. H. Williams and Staff.

Peripheral Vascular Disease:
Dr. C. E. Corrigan and Dr. L. R. Coke.

Modern Methods of Treatment of Hemiplegia:
Dr. W. M. Musgrove and Dr. John Matas.

Ioon

2.15 Luncheon, Deer Lodge Hospital.
Chairman—Dr. W. R. Dunlop, Senior Treatment Medical Officer, Deer Lodge Hospital.
Speaker—Col. John N. Crawford, M.B.E., E.D., Medical Directorate, Army Headquarters, Ottawa.
The General Practitioner and Civil Defence.

Afternoon

Deer Lodge Hospital.

2.15 1. The New Problems in Modern Warfare:
Col. J. N. Crawford, M.B.E., E.D., Medical Directorate, Army Headquarters, Ottawa.

2. The Management of Gall Bladder Disease and Its Complications:
Round Table Conference.
Chairman—Dr. J. Wendell Macleod.

Evening

8.15 Medical College.

1. Intestinal Obstruction:
Dr. W. C. MacKenzie, Professor of Surgery, University of Alberta.

2. Medical Diseases of Bone:
Dr. Ray Farquharson, Professor of Medicine, University of Toronto.

Friday, March 30th

Morning

Children's Hospital.

9.00 Clinical Program.

Noon

2.15 Luncheon, Children's Hospital.
Chairman—Dr. Bruce Chown.
"Information Please"
A battery of experts will answer questions on any subject in pediatrics.

Afternoon

Children's Hospital.

2.00 1. The Treatment of Some Common Skin Disorders in Children:
Dr. Arthur R. Birt.

2. "Abdominal Surgical Emergencies in Children."
Round Table Conference.
Chairman—Dr. H. Medovy.

Evening

Dinner — Speaker to be announced.

Enroll Early

The accepted registration is limited. Should you plan to attend, early enrollment is recommended. Applications for registration will be accepted in the order in which they are received.

SOCIAL NEWS

Reported by K. Borthwick-Leslie, M.D.

The only new applicant for my "Groaner's lub" is Gordon, and how he groans at those of s who hold up production of the "Review," by ot having our copy in on time. Speedy con-alescence, Gordon! May your symptoms all be leared up next month.*

♦

Dr. G. C. Fairfield was elected President of the ortage and District Progressive Conservative ssociation early in January. Congratulations.

♦

I understand Drs. Eddy and Gladys Cunning-am are en route home from China and Hong ong. They were expected to sail early in the ew Year.

♦

Rod and Mrs. Chadwick have also sailed for ngland, where they will remain for some time. ympathy to Rod and his wife on the loss of their fant daughter.

♦

Dr. Isabel McTavish, retired missionary from hina, was the guest speaker at a meeting of the anitoba Medical Women this month. The meet-g was held at the home of Helen Webb, Wilde-ood Park. I wasn't invited so don't know much ore of the Women's activities. Guess they are raid of the "Gossiper," but how could they be?

♦

Drs. Bruce and Helen Loadman are happy to nnounce the birth, Jan. 16, 1951. of Mary Eliza-eth.

*Diagnosis: Acute Appendidates. The groans are con-stently periodic. The onset appearing regularly on the th of each month. G.

A disastrous fire in the business section of Swan River, Man., in December caused the loss of office and contents to Drs. D. M. Harmon and Malcolm. Temporary offices were set up in the hospital.

♦

Congratulations to Dr. Jean Trudel of St. Boniface, who was reappointed a member of the Board of Governors, University of Manitoba, for the term expiring May, 1953.

♦

Dr. E. K. Maclellan, Halifax, N.S., died in Guelph, Ont., last week. Dr. Maclellan was one of Canada's outstanding obstetricians, having been Professor in his specialty for many years at Dalhousie University. William Edward Maclellan, his father, was formerly an editor of the Winnipeg Free Press.

♦

Dr. and Mrs. Colin Ferguson, Boston, Mass., are happy to announce the birth of their daughter on Jan. 10, 1951.

♦

Dr. and Mrs. J. Brook of Beausejour, Man., announce the arrival of Harriet Laurane, Jan. 8, 1951.

♦

Dr. and Mrs. Alan B. McCarten, Edmonton, announce the arrival of a son on Jan. 22.

The girls surely are leading so far in 1951.

♦

Dr. J. L. Downey is retiring as Medical Director of the Municipal Hospitals on March 1. I understand Dr. Downey will enter private practice, but more anon.

EDITORIAL

J. C. Hossack, M.D., C.M. (Man.), Editor

Your Business

Ladies and gentlemen, you are welcome to tend the Executive Committee Meetings of your ssociation. This is not an official invitation om the most potent, grave and reverend seniors, y very noble and approved good masters, who rm the Executive, but is a reminder that one of ir by-laws permits your presence. You will not ave voting privileges nor will you be expected take part in the discussions, but you may at-nd and thus should you so desire learn at first and what is being done in your interest.

I doubt if many will so desire. Taking it by id large the interest you take in your corporate siness is not great. You are willing to "let eorge do it." The "Georges" you have elected anfully shoulder your burden and theirs, em-oying their leisure time and sometimes working r into the night to advance your interests. 'hat you know about their doings you learn rough your eyes (in these pages) rather than rough your ears at meetings, annual or other-ise; and not always do you use even your eyes.

If you did not attend the last annual meeting id, for your absence, can offer only an excuse id not a reason, then you were guilty of an nkindness. It may be that you were so well tisfied with those to whom your affairs were ntrusted that you regard your absence as quivalent to a word of praise. But this negative rm of commendation does little to gratify those ho serve you. Your presence means that you e interested; it is evidence that you appreciate ie efforts put forth on your behalf; and it gives couragement to your representatives who made iese efforts. Your absence, on the other hand, either shows approval nor gladdens the heart, and, oreover, deprives your officers and fellow mem-ers of the benefit of your opinions and advice.

To men and women who have, throughout the ear, spent many hours in your service, it is dis-eartening to find themselves addressing empty nairs when the time comes for them to give an ccount of their stewardship. The officers of the ssociation and its Committees (and this applies so to the Winnipeg Medical Society) must often, id for long hours, tear themselves away from ieir contemplative reading of the Scriptures or hakespeare or some other such edifying enjoy-ient in order to arrange and study your affairs. he least you can do is to take an interest in their ctivities and be present when these are brought efore you at meetings.

From now on we hope to tell you more about our business in these pages. You will be kept in touch with all the matters before your Committees. Then, at the Annual Meeting, when you are well briefed, come and say your say. The business meeting of the Association is by no means the least important part of the Convention. Indeed it is the heart of the Convention.

From the standpoint of interest in business meetings sweet are the uses of adversity, "which, like the toad, ugly and venomous, wears yet a precious jewel in his head." So long as metaphorically the bell of the cash register rings often and merrily, and one pocket is too small to hold the day's takings, so long as such is the case few doctors will take much interest in their corporate affairs. The only times I have seen capacity audiences at business meetings were during the Depression, when, united and determined we bravely battled for permission to charge 25c for a hospital visit and a dollar for an office consultation. Ye gods and little fishes! Two bits for a hospital call! Eight bits for examination, diagnosis and advice! And yet, to such low ebb had fallen our fortunes, we were so elated when we won this famous victory, that we threw up our sweaty nightcaps and made the welkin ring. And when the smoke of battle had cleared we bore our dauntless leaders shoulder-high and feted them, as was most proper.

The Depression did not gather over night. There was a time when it was as a cloud no larger than a man's hand. Even now there are upon the horizon other such little clouds some of which are destined to grow big and black. The officers of your Association are aware of the presence and potentialities of these dangers. They must, like men upon a watch-tower, peering through the shrouding mists that hide the future, strain their eyes to see, in time, the shape of things to come.

Month by month you will be told the progress of their vigilance. Do not give your leaders the questionable approbation of indifference. Apathy is a far more deadly thing than criticism given honestly. You need the efforts of your officers but, to an equal degree, your officers need your interest and your help.

We Must Tell the Truth

The truth and the whole truth, it would seem, is what the law demands of us when we counsel our patients. If we believe a malady to be mortal we must say so without equivocation. Otherwise, buoyed up by false hope, a man may neglect to put his affairs in order—may even embark on new ventures the conclusion of which he can never see.

How often are we dogmatic in the matter of saying when a life will end? How often, indeed can we be dogmatic? Is not our private opinion many times contradicted by the event? We have, all of us, seen the apparently doomed recover perfectly and, per contra, death come when its intrusion appeared to be most unlikely.

If our prognostications were always correct there might be reason in the law which insists that we do not hide from our patient what appears clear to us. The law admits an "imperfect privilege" when the consultation concerns treatment and not merely prognosis. But, according to Weiss (a Research Fellow in Legal Medicine at Harvard, writing in the New England Journal of Medicine, May, 1950) "Suppression of fact or concealment in diagnosis is a clear breach of employment and abuse of trust sounding in tort for legal negligence." For this a doctor can be sued.

Justice is pictured with a blindfold covering her eyes. But not so Aesculapius. The law is dispassionate and practical. Medicine also is practical, but it is compassionate. Blinded Justice cannot see the features of the condemned distorted by anguish and despair. Her judgments are delivered harshly with little thought of softening the blow. "Man seems likest God," said Portia, "When Mercy seasons Justice." Justice is not always so seasoned. But Nature is kind to the dying. The coming of Death seldom provokes a struggle. Most "pass through slumber to a dream and through a dream to death." And as Nature is kind, so also should we be kind who are Nature's assistants and servants. The judge, awed by his dreadful responsibility, may be able only to mutter in tremulous whisper the formula prescribed by law, and for months thereafter the words echo in his mind. For months, also, the harassing thought of the shortness of his days is uppermost in the prisoner's mind, because the law is punitive and means that the condemned should watch in torment the shrinking of his life to seconds.

The judge must say the words he is told to say and he speaks them only to those who have taken life and whose load of guilt has been laid bare. Yet he is shaken by the disagreeable task which he performs so infrequently. The law would have us deliver the same message to the guiltless. To us it is no less distressing than to the judge and, unfortunately, has more often to be considered. Yet, if we would obey the law, we must tell a man "You are about to die" when such is our belief—only our belief. We may be wrong and cause him much needless anguish or we may be right, in which case we replace hope with despair, and rob him of his peace of mind. We might, moreover, suspend our efforts to help him and thereby ha the fulfillment of our prediction.

Far from being punitive the object of our fession is to bring peace of mind as well as fort of body to the sick. A sentence of death w do neither. On the other hand we may tell quite truthfully that his ailment is one with w it is difficult to contend; one from which few cover. But, if we are to be quite truthful must say also that he may be one of that few this assurance he may give heed to our ad to set his affairs in order, for it is better to prepared than to die unprepared. Thus can obey the law and yet mitigate its blow.

Medicine is not unlike the law. The do must play the role of detective. He is cou for the prosecution and also, until he is sure the defence. He is above all, the judge. He struggle (and sometimes it is a struggle) ag the bias of an advocate, and seek to emulate impartiality of a judge. But the sentence of d should never be on his lips—who knows wh or when may come a reprieve?

Yet the law, which takes little heed of pers feelings, says we must speak the truth as we it even though the event may prove our tru lie. Faced with such an order must we no times ask ourselves — as Pilate did — quid veritas? What is the truth? And, for those obviously in articulo mortis, how can we tell?

Against this callous legal pronouncement is more pleasing instruction, not of Aesculapius of one of his most eminent (and humanita disciples—Oliver Wendell Holmes:

"If you are making choice of a physician sure you get one, if possible, with a cheerful serene countenance. A physician is not—at ought not to be—an executioner; and a sen of death on his face is as bad as a warrant execution signed by the Governor. As a ge rule, no man has a right to tell another by or look that he is going to die. It may be neces in some extreme cases; but as a rule, it is the extreme of impertinence which one human can offer to another. "You have killed me," a patient once to a physician who had rashly him he was incurable. He ought to have live months, but he was dead in six weeks. If we only let Nature and the God of Nature alone, sons will commonly learn their condition as as they ought to know it, and not be cheated of their natural birthright of hope of reco which is intended to accompany sick peop long as life is comfortable, and is graciously placed by the hope of heaven, or at least of when life has become a burden which the b is ready to let fall."

Medico-Historical

J. C. Hossack, M.D., C.M. (Man.)

Dr. Mead and His Museum

Foremost among the medical men of the last century, for his professional skill, his amiable manners, and princely munificence, ranks Dr. Richard Mead, who was consulted beside the death-bed of Queen Anne, and became physician to George II. He was born at Stepney, near London, in 1675; and after studying in continental schools, and taking the degree of Doctor of Medicine at Padua, he settled at his native village, and there established his reputation. Among his early services were his researches in experimental physiology, for which no small degree of courage was necessary. He handled vipers, provoked them, and encouraged them to seize hold of hard bodies, on which he imagined that he could collect their venom in all its force. Having obtained the matter, he conveyed it into the veins of living animals, mixed it with human blood, and even ventured to taste it, in order to establish the utility of sucking the wounds inflicted by serpents.

Mead was instrumental in promoting inoculation for the smallpox: the Prince of Wales desired him, in 1721, to superintend the inoculation of some condemned criminals, intending afterwards to encourage the practice by employing it in his own family; the experiment amply succeeded, and the individuals on whom it was made recovered their liberty. When the terrible plague ravaged Marseilles, and its contagious origin was discredited, Dr. Mead, after a careful examination of the subject, declared the plague to be a contagious distemper, and a quarantine was enjoined; and he proposed a system of Medical Police, in a tract of which seven editions were sold in one year. Through Dr. Mead's influence Sutton's invention for expelling the foul and corrupted air from ships was tried, and its simplicity and efficacy proved; a model of Sutton's machine made in copper was deposited in the museum of the Royal Society, and the ships of His Majesty's navy were provided with it. The fact that, in each of these cases, Mead's results have been superseded by more recent discoveries, does not in the least detract from his merit. What he effected was, for his time, wonderful.

Mead was fast approaching the summit of his fortune, when his great protector, Radcliffe, died, and Mead moved into his house in Bloomsbury-square. After the most brilliant career of professional and literary reputation, of personal honour, of wealth, and of notoriety, which ever fell in combination to the lot of any medical man in any age or country, Mead took to the bed from which he was to rise no more, on the 11th of February, and expired on the 16th of the same month, 1754. His death was unaccompanied by any visible signs of pain.

In practice, Dr. Mead was without a rival; his receipts averaging, for several years, between six and seven thousand pounds, an enormous sum in relation to the value of money at that period. He daily sat in Batson's coffee-house, in Cornhill, and at Tom's, in Russell-street, Coventgarden, to inspect written, or receive oral, statements from the apothecaries, prescribing without seeing the patient, for a half-guinea fee. He gave advice gratuitously, not merely to the indigent, but also to the clergy, and all men of learning.

Dr. Mead had removed into Great Ormond-street, Queen-square, several years before his death: the house is No. 49, corner of Powis-place; behind his house was a good garden, in which he built a gallery, and museum. There Mead gave conversazioni, which were the first meetings of the kind. He possessed a rare taste for collecting; but his books, his statues, his medals, were not to amuse only his own leisure: the humble student, the unrecommended foreigner, the poor inquirer, derived almost as much enjoyment from these treasures as their owner; and he constantly kept in his pay several scholars and artists, who laboured, at his expense, for the benefit of the public. His correspondence extended to all the principal literati of Europe, who consulted him, and sent him many curious presents. At his table might be seen the most eminent men of the age. Pope was a ready guest, and the delicate poet was always sure to be regaled with his favourite dish of sweetbreads. Politics formed no bar of separation: the celebrated physicians, Garth, Arbuthnot, and Freind, were not the less his intimate associates because they were Tories. When Freind was sent to the Tower for some supposed political offence, Mead frequently visited him, and attended his patients in his absence; from Sir Robert Walpole he procured his liberation, and then presented him with a large sum, being the fees which he had received from his brother practitioner's clients. He also persuaded the wealthy citizen, Guy, to bequeath his fortune towards the noble hospital which bears his name.

Although Mead's receipts were so considerable, and two large fortunes were bequeathed to him, his benevolence, public spirit, and splendid mode of living, prevented him from leaving great wealth to his family. He, whose mansion was a sort of open house for men of genius and talent, who kept a second table for his humbler dependents, and who was driven to his country house,

near Windsor, by six horses, was not likely to amass wealth; but he did better: he acted according to his own conviction, that what he had gained from the public could not be more worthily bestowed than in the advancement of the public mind; and he truly fulfilled the inscription which he had chosen for his motto: "Non sibi, sed totl."

After Dr. Mead's death the sale of his library and museum realized between fifteen and sixteen thousand pounds, his pictures alone producing £3400. The printed catalogue of the library contains 6592 separate numbers; Oriental, Greek and Latin manuscripts forming no inconsiderable part: the greater portion of the library he bequeathed to the College of Physicians. The collection included prints and drawings, coins and medals, marble statues of Greek philosophers and Roman emperors; bronzes, gems, intaglios, Etruscan and other vases; marble busts of Shakespeare, Milton and Pope, by Scheemakers; statues of Hygeia and Antinous; a celebrated bronze head of Homer; and an iron cabinet (once Queen Elizabeth's), full of coins, among which was a medal, with O Cromwell's head in profile; legend "The Lo Hosts," the word at Dunbar, 1650; on the re the Parliament sitting.

Of so worthy a man as Dr. Mead mem are interesting: in the College of Physicians fine bust of him, by Roubiliac; and here i portrait, and the gold-headed cane which h ceived from Radcliffe, and which was after carried by Askew, Pitcairn, and Matthew Ba Among the pictures at the Foundling Hospit Dr. Mead's portrait, by Allan Ramsay; and i nave of Westminster Abbey is a monument t worthy physician.

Dr. Mead was a clever person, but Dr. W ward had the better of him in wit: when fought a duel under the gate of Gresham Co Woodward's foot slipped, and he fell. "Take life," exclaimed Mead. "Anything but physic," replied Woodward. The quarrel from a difference of opinion on medical sub

Pittegrew—Lives of British Physi

Sickness and Accident Assurance

We would remind you again of the Group Sickness and Accident Assurance which every member of the Association should have. During the two years it has been in force many have enjoyed its benefits. The plan is a generous one. Pre-existing ailments are not excluded. Mr. Brunning, the Company's local agent, has shown that he wishes every policy holder to be well satisfied. There is no careful scrutiny of the small print to see if something, given by the large print, can be taken away. We are dealing with an honest company that discharges its obligations promptly and without quibbling. Remember that continuance of the plan depends upon the requirement that at least 50% of our membership are subscribers. Doctors are as prone to sickness and as vulnerable to accidents are are laymen. The 25c a day which the policy costs can nowhere be invested more profitably and the larger the number of subscribers the greater the assurance that all will be protected. If you do not have a policy get in touch with W. E. Brunning, 710 Electric Railway Chambers, Winnipeg. This is for country doctors as well as for those in the city.

Clinical Luncheons

Time Table for Clinical Luncheons held d the Season in Greater Winnipeg Hospitals. days in each month on which the luncheon held are listed herewith. Visiting doctors are come.

1st Monday—Deer Lodge Hospital.
1st Tuesday—Municipal Hospital.
1st Thursday—Winnipeg General Hospital
1st Friday—Children's Hospital.
2nd Tuesday—Misericordia Hospital.
2nd Thursday—St. Boniface Hospital.
2nd Friday—Victoria Hospital
3rd Tuesday—Grace Hospital.
3rd Thursday—Winnipeg General Hospital
4th Tuesday—St. Joseph's Hospital.
4th Thursday—St. Boniface Hospital.

Anaesthesiology Section

1st Tuesday—Regular meetings of the Anae thesiology Section of the Winnip Medical Society. Visiting anaesthet are welcome.

ASSOCIATION PAGE

Reported by M. T. Macfarland, M.D.

THE CANADIAN MEDICAL ASSOCIATION

135 St. Clair Ave. West,
Toronto, Ont.

To Secretaries of Divisions

January 5th, 1951.

Dear Doctor Macfarland:

Re: The C.M.A. Journal

Many years ago some Doctors thought that Canadian Medical Association membership was synonymous to an annual subscription to the Journal. This meant that a Doctor joining the Association any time during the first half of the year was sent twelve issues of the Journal including back numbers for that calendar year. This practice grew until in recent years we have been sending out thousands of back Journals at a very considerable cost to the Association.

Such inquiries as we have been able to make give little support to the continuation of this practice, as busy Doctors do not appear to have too much time to read all the current literature which reaches them, let alone digging into Journals of bygone months.

Accordingly we propose to discontinue the practice. New members joining the Association will receive the Journal for the balance of the calendar year in which they join. It is to be remembered that the Journal is one of the perquisites of membership and it is our obligation to provide it at and from the time membership is completed, but not for any period prior to that date.

We are sure that you will appreciate our desire to hold mounting printing costs down wherever possible and this appears to us as one item that merits correction.

Yours sincerely,

General Secretary
and
Managing Editor.

Income Tax Information

Individuals whose income—(a) is derived from carrying on a business or profession (other than farming); (b) is derived from investments; or (c) is more than 25% derived from sources other than salary or wages, are required to pay their estimated tax by quarterly installments during such year. Each payment must be sent in with Instalment Remittance Form T.7-B Individuals. Any balance of tax is payable with interest with the T-1 General return which is due to be filed on or before April 30 of the succeeding year.

The following timetable indicates the returns required.

A. Doctors NOT receiving salaries amounting to ¾ of income:

Date Due	Forms to be used
March 31	T. 7-B Individuals
April 30	T. 1-General (Note: Only doctors deriving their full professional income from salaries may use Form T. 1 Short.)
June 30	T. 7-B Individuals
Sept. 30	T. 7-B Individuals
Dec. 31	T. 7-B Individuals

B. Doctors receiving salaries amounting to ¾ or more of income:

Date Due	Forms to be used
April 30	T. 1-General (Note: Only doctors deriving their full professional income from salaries may use Form T. 1 Short.)
Whenever Status is changed (with respect to new employer, marital status, dependents)	T.D.-1

Doctors who pay salaries to their own employees are required to send in **Form T.-4 by the end of February each year.**

For income tax purposes all salaries are net. Therefore doctors must pay tax on the total amount they receive as salary. Doctors are urged to arrange with their employers that such items as automobile expenses and medical association fees, be paid by the employer as an item of expense and not included in salary.

Dominion Income Tax Returns by Members of the Medical Profession

As a matter of guidance to the medical profession and to bring about a greater uniformity in the data to be furnished to the Income Tax Division of the Department of National Revenue in the annual Income Tax Returns to be filed, the following matters are set out:

Income

1. There should be maintained by the doctor an accurate record of income received, both as fees from his profession and by way of investment income. The record should be clear and capable of being readily checked against the return field. It may be maintained on cards or in books kept for the purpose.

Expenses

2. Under the heading of expenses the following accounts should be maintained and records supported by vouchers kept available for checking purposes:

(a) Medical, surgical and like supplies;

(b) Office help, nurse, maid and bookkeeper; laundry and malpractice insurance premiums. (It is to be noted that the Income Tax Act does not

allow as a deduction a salary paid by a husband to a wife or vice versa. Such amount, if paid is to be added back to the income);

(c) Telephone expenses;

(d) Assistants' fees; The names and addresses of the assistants to whom fees are paid should be furnished. This information is to be given each year on Income Tax form known as Form T.4, obtainable from your District Income Tax Office;

(e) Rentals paid; The name and address of the owner (preferably) or agent of the rented premises should be furnished (see (i));

(f) Postage and stationery;

(g) **Depreciation;** Effective with the taxation year 1949, a very significant change has been made with respect to the method of computing annual depreciation charges on capital equipment. This new method is termed **Capital Cost Allowance** and is outlined in P.C. 6385, dated December 21st, 1949. All previous information published to the profession pertaining to depreciation on both medical equipment and motor cars and on residences used for both dwelling and office purposes should be disregarded.

For the first time, definite rates of depreciation applicable to various kinds of capital assets have been defined. These rates are grouped by classes. The physician will find the following examples helpful as a first step in computing the annual depreciation on his equipment or other capital items:

Capital Item	Class	Annual Maximum Depreciation
Medical Equipment, including electrical apparatus:		
(a) Instruments costing over $50 each and medical apparatus of every type	8	20%
(b) Instruments under $50 each	12	100%
Office Furniture and Equipment	8	20%
Motor Car	10	30%
Building (Residence used both as dwelling and office):		
Brick	3	5%
Frame, Stucco	6	10%

Replacing the previous method of charging off depreciation rateably over the estimated life of the asset, the above rates are applied as a percentage of the diminishing value each year.

An instrument acquired at a cost of $100 will be treated as follows:

Original Cost	$ 100.00
Depreciation 1st year — 20%	20.00
Diminished Value End of 1st Year	$ 80.00
Depreciation 2nd year — 20%	16.00
Diminished Value End of 2nd Year	$ 64.00
Depreciation 3rd year — 20%	12.80
Diminished Value End of 3rd Year	$ 51.20

(Continued until asset reduced to negligible amou

The same procedure is applicable to the of each class mentioned above by applying correct percentage rate applicable.

To establish the present value of items acq before the institution of the system of Capital Allowance, the physician should deduct from original cost the amount of depreciation al claimed.

When a doctor uses part of his dwelling a office the office premises now take a separate for depreciation purposes. Where one-third o total space is occupied as office and waiting-r the professional quarters in a $12,000 hous deemed to have a cost of $4,000. Where a do increases his office space in his home, he sh consult his local Income Tax Office to deter the basis for depreciation.

(h) Automobile expenses; (one car).

This account will include cost of license gasoline, grease, insurance, garage charges repairs.

The capital cost allowance is restricted to car used in professional practice and does apply to cars for personal use.

Only that portion, of the total automobile pense, incurred in earning the income from practice may be claimed as an expense and th fore the total expense must be reduced by portion applicable to your personal use.

(The alternative method of claiming deduct for the operation of a motor car in practice rate of 7 cents per mile is no longer applic Physicians must maintain a record of actual o ating expense. The mileage rate may be use the Department only in those cases where it is possible to determine the actual car expense plicable to the practice).

(i) Proportional expenses of doctors pract from their residence:

Column (1) Class Number or Kind of Asset	(2) Original Cost (excluding land)	(3) Total Depreciation Accumulated for Tax Purposes in Prior Years	(4) Undepreciated Cost at Beginning of year (Col. 2 less Col. 3	(5) Cost of Additions During Year	(6) Proceeds from Disposals During Year	(7) Undepreciated Capital Cost Before 1949 Allowance (Col. 4 plus 5 less 6)	(8) Rate %	(9) Cap Co Allow
A motor car 10	purchased i	n 1948 for $2,5	00 and still on	hand at end	of 1950.			
	$2,500	$1,000	$1,500	.....	.....	$1,500	30%	$4
A motor car 10	purchased i	n 1948 for $2,5	00, sold in 1950	for $1,500 an	d replaced by	the purchase of	a new car.	
	$2,500	$1,000	$1,500	$2,500	$1,500	$2,500	30%	$7

(a) Owned by the doctor.

When a doctor practises from a house which he owns and as well resides in, a proportionate allowance of house expenses will be given for the study, laboratory, office and waiting room space, on the basis that this space bears to the total space of the residence. The charges cover taxes, light, heat, insurance, repairs, capital cost allowance, and interest on mortgage (name and address of mortgagee to be stated);

(b) Rented by the doctor.

The rent only will be apportioned inasmuch as the owner of the premises takes care of all other expenses. The above allowances will not exceed one-third of the total house expenses or rental unless it can be shown that a greater allowance should be made for professional purposes.

(j) Sundry expenses (not otherwise classified)—The expenses charged to this account should be capable of analysis and supported by records.

Claims for donations paid to charitable organizations will be allowed up to 10% of the net income upon submission of receipts to your Income Tax Office. This is provided for in the Act.

The annual dues paid to governing bodies under which authority to practice is issued and membership association fees, to be recorded on the return, will be admitted as a charge. Registration fees for license to practice or other registration or entry fees and the cost of attending postgraduate courses will not be allowed.

(k) Carrying charges: The charges for interest paid on money borrowed against securities pledged as collateral security may only be charged against the income from investments and not against professional income.

(l) Business tax will be allowed as an expense, but Dominion, Provincial or Municipal income tax will not be allowed.

Convention Expenses

"Effective January 1, 1948, the reasonable expenses incurred by members of the medical profession in attending the following Medical Conventions will be admitted for Income Tax purposes against income from professional fees:

1. One Convention per year of the Canadian Medical Association.

2. One Convention per year of either a Provincial Medical Association or a Provincial Division of the Canadian Medical Association.

3. One Convention per year of a Medical Society or Association of Specialists in Canada or the United States of America.

The expenses to be allowed must be reasonable and must be properly substantiated: e.g., the taxpayer should show (1) dates of the Convention; (2) the number of days present, with proof of claim supported by a certificate of attendance issued by the organization sponsoring the meeting; (3) the expenses incurred, segregating between (a) transportation expenses, (b) meals and (c) hotel expenses, for which vouchers should be obtained and kept available for inspection.

None of the above expenses will be allowed against income received by way of salary since such deductions are expressly disallowed by statute."

Professional Men Under Salary Contract

3. Under the provisions of the Income Tax Act the salary paid to a doctor is taxable in full without any allowance for the deduction of automobile expenses, annual medical dues or other expenses. The employees' annual contribution to an approved Pension Plan and alimony payments, however, may be deducted from salary, as may charitable donations.

Section 5 of the Income Tax Act reads as follows:

"Section 5: Income for a taxation year from an office or employment is the salary, wages and other remuneration, including gratuities, received by the taxpayer in the year plus

(a) The value of board lodging and other benefits (except the benefit he derives from his employers contributions to or under an approved superannuation fund or plan, group insurance plan or medical services plan) received or enjoyed by him in the year in respect of, in the course of, or by virtue of the office or the employment, and

(b) All amounts received by him in the year as an allowance for personal or living expenses or AS AN ALLOWANCE FOR ANY OTHER PURPOSE .....

minus the deductions permitted by paragraph (g), (j) and (o) of sub-section (I) of Section II and by sub-sections (V), (VI) and (VII) of Section II but without any other deductions whatsoever."

According to Section 5 of the Income Tax Act both the salary and the fixed expense allowance of certain MUNICIPAL DOCTORS may be taxable in full without permitting deduction of the expenses which the fixed allowance was intended to cover. It is suggested, therefore, that the present contracts be revised (a) to make provision for the vouchering of the doctor's expenses by the municipality concerned OR (b) for the doctor to render periodically to the municipality a proper accounting for the expenses supported by vouchers. In the latter case it would be acceptable if the amounts reimbursed to the doctor were less than the expense accounts submitted. Therefore if such a procedure were adopted by the Municipality the latter would be obliged to show on the T.4 wage slip only the salary portion of his remuneration, not the reimbursement for such out-of-pocket expenses incurred solely in discharging his duties under the agreement.

It may be pointed out that contributions by the doctor to an approved pension plan are deductible from his income, but that if the pension plan is

not approved the employer's contributions may be considered income in addition to his salary. Likewise any contributions by the employer to pay the premiums of a sickness and accident insurance policy on behalf of the doctor would constitute additional income to the doctor.

(Above information was mailed on January 12th, 1951, to Municipal Physicians in Manitoba).

Bulletin of the A.C.S.

Received recently in the Association office is the "Approval Number," Bulletin of the American College of Surgeons, for December, 1950. A wealth of material is contained in the 263 pages of the Bulletin, including the names of seventeen Manitoba Hospitals which have been approved by the College. Other information concerns Graduate Training in Surgery, Cancer Clinics, Cancer Detection Centres, Medical Services Industry, and Medical Motion Picture Films.

Cancer Diagnostic Services Referral Forms

Announcement regarding the initiation of Cancer Diagnostic Services at the Winnipeg General and St. Boniface Hospitals was made in the Manitoba Medical Review for January.

A booklet of the special forms for use in referring Cancer suspects from rural Manitoba, whose financial status would prohibit them from paying for the service, has recently been sent out to all doctors. A stub enables the physician to maintain a record of the case referred. The booklet contains ten Referral Forms of post-card size, which may easily be slipped into an envelope. Also included is a salmon-colored card which indicates that a new booklet is required. Additonal booklets of the forms are available, upon request, from the Manitoba Cancer Institute, 442 William Avenue, Winnipeg.

Sickness Survey

The December, 1950, Issue of "Canada's Health and Welfare," outlines some features of the Sickness Survey which got underway in the Fall, is scheduled to continue throughout one year, and is expected to produce "a mass of new information concerning the health of Canada's people, their illnesses and accidents large and small, what they spend on hospitals, doctors and drugs, their health environments, their chronic illnesses, their acute diseases and their minor ills."

Complaints Against Physicians

The Journal of the American Medical Association for October 21st, 1950, indicates, under the above heading, that 34 of the 48 Constituent State Medical Associations and the District of Columbia Medical Society now have Committees which will hear complaints from the public. The Committees are commonly known as Committees of Professional Conduct, but are sometimes popularly called "Grievance Committees." They reflect the broad interest of physicians in the h of their patients. They also reflect the determ tion of the Medical Associations to resolve own problems. The Canadian Doctor, for De ber, 1950, outlined steps taken by the Colo State Medical Society and the Oklahoma Medical Association.

The profession in this province may be i ested in the formation of such a Committee, w work has been carried on without the fanfa publicity over a period of years.

D.V.A. Treatment Regulations

A circular letter dated November 3rd was out over the signature of Dr. W. R. Dunlop, Se Treatment Medical Officer of all doctors in Manitoba and Western Ontario. This cir letter indicates the eligibility of veterans to ob treatment from their own doctor and in their hospitals at D.V.A. expense. It indicates desire of the Department to co-operate as fa possible with doctors of the Manitoba Me Association to ensure that veterans who a responsibility of the Department receive im diate and first-class treatment, when it is nee

Executive Committee

Present at the meeting which was held on afternoon of December 17th, 1950, were: Doc Eyjolfur Johnson, Chairman; S. S. Toni, A Goodwin, W. F. Tisdale, C. W. Wiebe, R. W. W ter, C. B. Schoemperlen, A. E. Childe, R Lyons, W. G. Ritchie, D. L. Scott, H. W. C. N M. T. Macfarland, Elinor F. E. Black, A. S. L R. W. Richardson, L. A. Sigurdson.

Report of Representative to C.M.A. Execut

Dr. R. W. Richardson presented a com hensive report of the November 23-24 meetin Montreal, including plans for the Annual Mee at the latter city in June, 1951. It is anticip that sufficient hotel accommodation will be a able.

Financial attention was focused on the s operating deficit for which corrective steps suggested in the budget. The matter of collec a registration fee from each person attending Annual Meeting was referred to the Division opinion.

Following the report of the Editor, Cana Medical Association Journal, there was cons able discussion of methods for making periodical truly representative of the cult educational, scientific and economic aspect Association activities.

Other matters on the agenda related to rev of Constitution and By-laws, including the Se on General Practice; the necessity of establis a permanent home for the Association, the of the medical profession in national disaster p ning and in the program of hospital standard tion.

Economic considerations were very much to he fore, evidenced by the discussion which centred bout the composition, time and place of Committee meetings, the impact of the health plan uggested for Australia by Sir Earle Page, Minister of Health for that Commonwealth, discussions ith the Canadian Life Insurance Officers Association, and those between the profession and overnment in the Province of Alberta. There as little new information concerning the hositalization of non-entitled veterans in Departent of Veterans Affairs Hospitals.

More complete details of the C.M.A. Executive ommittee meeting are included under the headg "Association Notes" on page 77 of the Canaian Medical Association Journal for January, 951.

Following receipt of Dr. Richardson's report, he following resolutions were approved by the Ianitoba Division, Executive Committee:

Registration Fee

"THAT the Manitoba Division approves the egistration Fee of $5.00 being charged by the anadian Medical Association at Annual Meetngs."

Permanent Home for C.M.A.

"THAT the Manitoba Division approves the eport of Committee on Housing, which recomends that site for home of the Canadian Medical ssociation should be in Toronto."

Date of Annual Meeting, Manitoba Division

"THAT the Annual Meeting of the Manitoba ivision for 1951 (October 9-10-11) be held in the ort Garry Hotel."

Fee Committee

"THAT the President and the Executive Secetary be instructed to meet with the Chairman f the Board of Trustees, Manitoba Medical Serice, and draw up an agreement as to who shall e responsible for setting the Fee Schedule for Manitoba Medical Service; this agreement to be n the form of a resolution so that both bodies vill have something by which to guide them in he future."

"THAT this Executive approve Reports of Fee Committee of September 29th, November 30th nd December 12th."

Editorial Committee—Manitoba Medical Review

Notice of motion: "THAT this Executive at its ext meeting discuss the general policy for the Manitoba Medical Review and that the Editor nd/or Associate Editor be invited to attend that neeting."

Obstetrical & Gynaecological Section

"THAT the Obstetricians and Gynaecologists e accepted as a Section of the Manitoba Medical Association."

C.P. & S.—Grants for Extra-Mural Postgraduate Work

"THAT letter be addressed to the College of Physicians and Surgeons of Manitoba expressing thanks for these grants, and especially the donation towards Extra Mural Postgraduate Work is greatly appreciated, and incorporate motion in Minutes of October 22nd re District Medical Societies."

"Sir Earle Page Plan"

The address by the Rt. Hon. Minister of Health for Australia was reproduced in the December Issue of the Manitoba Medical Review and commented on in the Winnipeg Free Press on December 11th, 1950. It was agreed that the outline might be useful in the work of the Public Relations Committee.

The Role of the Profession in National Disaster Planning

The Executive Secretary attended the second National Disaster Services Institute arranged by the Red Cross in November. Definite plans will soon be required on the Federal, Provincial and Municipal Planning levels, and the matter was referred to the senior officers of the Executive for action.

Canadian Foundation for Poliomyelitis "March of Dimes"

A campaign for funds was inaugurated one year ago. Some information was secured at the time through the Better Business Bureau. A provincial committee was named by the Minister of Health to investigate the organization and its constitution, aims and objects. Considerable controversy has stirred concerning whether or not a provincial chapter of the Foundation should be formed. The profession in Saskatchewan, approached for approval, deferred and referred the matter to the Canadian Medical Association for investigation.

Municipal Physician Contract

With increasing demands by the clientele covered under the contract, with increasing costs of conducting the practice, and of meeting living costs which are mounting to new levels, many men who hold municipal physician contracts are seeking revision of the terms. All are reminded that there is a standard or model contract form agreed upon between the Union of Rural Municipalities, the Manitoba Medical Association and the Advisory Commission under the Health Services Act. Details are available, as also is any assistance which the Association may give.

Society for Crippled Children of Manitoba

Association representatives report increasing activity by the Society. Discussion of the manner in which referrals will be carried out, and the fee schedule which will be utilized are under advisement.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1950 Dec. 3 to Dec. 30,'50	1950 Nov. 5 to Dec. 2,'50	1949 Dec. 4 to Dec. 31,'49	1949 Nov. 6 to Dec. 3,'49	Total Jan. 1 to Dec. 30,'50	Total Jan. 1 to Dec. 31,'49
Anterior Poliomyelitis	0	3	3	2	16	121
Chickenpox	219	242	204	345	1665	1741
Diphtheria	0	0	1	1	16	18
Diarrhoea and Enteritis, under 1 yr.	4	8	8	15	130	299
Diphtheria Carriers	0	0	0	1	3	5
Dysentery—Amoebic	0	0	0	0	1	0
Dysentery—Bacillary	0	2	1	4	128	32
Erysipelas	1	2	2	3	48	32
Encephalitis	0	1	0	1	2	37
Influenza	3	6	13	19	160	243
Measles	214	138	268	465	1539	6144
Measles—German	0	2	1	2	35	108
Meningococcal Meningitis	2	2	0	1	16	26
Mumps	113	132	10	16	616	966
Ophthalmia Neonatorum	0	0	0	0	2	1
Pneumonia—Lobar	21	14	18	21	223	215
Puerperal Fever	0	0	0	0	4	5
Scarlet Fever	37	81	48	102	444	299
Septic Sore Throat	1	2	0	11	48	51
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	2	3
Trachoma	0	0	0	0	0	5
Tuberculosis	83	64	3	73	925	1155
Typhoid Fever	0	1	5	0	4	17
Typhoid Paratyphoid	1	0	0	0	1	1
Typhoid Carriers	0	0	0	0	2	4
Undulant Fever	3	1	1	4	31	28
Whooping Cough	97	79	11	6	476	183
Gonorrhoea	99	94	87	108	1316	1426
Syphilis	12	21	29	28	227	407
Tularemia	0	0	0	0	5	0

Four-Week Period, December 3rd to December 30th, 1950

DISEASES (White Cases Only) Approximate population.	*779,000 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
Anterior Poliomyelitis		4	5	15
Chickenpox	219	434	1937	
Diarrhoea and Enteritis (under 1 year)	4			
Diphtheria		1	4	16
Diphtheria Carriers				
Dysentery—Amoebic				1
Dysentery—Bacillary			23	2
Encephalitis Epidemica		1		
Erysipelas	1	3	1	
Influenza	3		6	1
Jaundice, Infectious			15	
Measles	214	80	4547	225
German Measles		43	228	
Meningitis Meningococcal	2		11	5
Mumps	113	449	1481	
Ophthalmia Neonatorum				
Pneumonia, Lobar	21			
Puerperal Fever				
Scarlet Fever	37	54	191	56
Septic Sore Throat	1	2	4	20
Smallpox				
Tetanus				
Trachoma				
Trichinosis			2	
Tuberculosis	85	28	87	170
Typhoid Fever		1	4	
Typh. Para-Typhoid	1	6	2	
Typhoid Carrier				
Undulant Fever	3		2	17
Whooping Cough	97	2	415	73
Gonorrhoea	99		199	
Syphilis	12		81	

DEATHS FROM REPORTABLE DISEASES
For the Month of December, 1950

Urban — Cancer, 44; Pneumonia, Lobar (108, 107, 109), 2; Pneumonia (other forms), 8; Pneumonia of newborn, 1; Syphilis, 1; Tuberculosis, 5; Whooping Cough, 1; Neoplasms of lymphatic and haematopoietic tissues, 1; Benign neoplasms, 2. Other deaths under 1 year, 23. Other deaths over 1 year, 179. Stillbirths, 13. Total, 215.

Rural — Cancer, 37; Pneumonia, Lobar (108, 107, 109), 5; Pneumonia (other forms), 5; Syphilis, 1; Tuberculosis, 5; Septicaemia and pyaemia, 1; Neoplasms of lymphatic and haematopoietic tissues, 3; Gastro-enteritis and colitis, 2. Other deaths under 1 year, 21. Other deaths over 1 year, 178. Stillbirths, 10. Total, 209.

Indians — Pneumonia (other forms), 1; Tuberculosis, 1. Other deaths under 1 year, 5. Other deaths over 1 year, 2. Stillbirths, 2. Total, 9.

♦

This report shows the morbidity of communicable diseases for the last four week period in 1950 and also for the full year. Total figures for the year are always of interest.

It is easily seen that we have been fortunate in 1950 insofar as communicable diseases are concerned but we must not become complacent or our good fortune will not last. At time of writing a death due to diphtheria in a young child who had not been immunized has just been reported. This death was preventable and the parents are at fault because they had not taken the child to their doctor for toxoid.

We must continue to educate the people regarding prevention of disease and encourage them to take advantage of all facilities for prevention and furthermore we must provide these facilities and make them easily available.

COLLEGE OF PHYSICIANS AND SURGEONS OF MANITO

Council Meeting

October 18, 1950.

Business Arising from Minutes of Executive Committee Meeting Held Sept. 21, 1950

(a) Reciprocal Relations With the Medical Board of South Australia

The Registrar explained that the Medical Board of South Australia accepted those physicians with qualifications as listed in Table I of the Commonwealth List of the 1949 Medical Register of the General Medical Council of Great Britain, in which the C.P. & S. of Manitoba was included. He advised that if this body ratifies the reciprocal relations with South Australia, it could be incorporated in the by-laws at the appropriate time. The Registrar was instructed to advise the Medical Board of South Australia that the C.P. & S. of Manitoba was prepared to accept registrants of their Board.

Motion: "THAT reciprocity between the College of Physicians and Surgeons of Manitoba and the Medical Board of South Australia be ratified and incorporated into the by-laws of the College." Carried.

(b) Unlicensed Physicians in Manitoba

The Registrar presented a list of approximately 70 physicans in the Province of Manitoba who were not licensed with the College of Physicians and Surgeons of Manitoba, including members of the Permanent Armed Forces, hospital internes and anaesthetists, Displaced Persons, Dominion Government employees, teaching and research, and one non-graduate who is practising but not licensed in this or any province.

The Chairman suggested these should be divided into the various categories as outlined in Section 33A of the Medical Act.

(i) Members of His Majesty's permanent forces stationed in Manitoba, and full time employees in the public service of Canada stationed in Manitoba.

This group includes O.C., Deputy O.C., M.O.s looking after troops only, hospital superintendents, who are not practising medicine in the ordinary sense of the term. Members of the armed forces and employees of the Indian Health Services claim they are posted from one province to another and do not feel they should be required to be fully registered in each province to which they are moved.

Dr. Walton suggested the by-laws might be modified to accept for temporary licence, members of the permanent armed forces and employees of the Department of National Health and Welfare, who are permanently registered in one province, and whose registration is in good standing, payment of the Five Dollar ($5.00) annual fee this province. Proof of registration and standing in another province would be requi He stated the aim was to remove some of the jections which had been raised by the Domi Government.

Notice of Motion by Dr. C. H. A. Walton:

"THAT members of His Majesty's perma forces stationed in Manitoba, and full time ployees in the public service of Canada statio in Manitoba, be accepted for temporary lic with the College of Physicians and Surgeons Manitoba, provided they are registered and i standing with one Province of Canada, upon ment of the annual fee."

The Registrar was requested to obtain solicitor's opinion.

(ii) Graduate internes employed full time hospital in Manitoba.

It was agreed that internes should be licen It was suggested that the internes did not k about temporary licensing, and that an appro should be made to the hospitals that registra should be required for interneship, and poin out the risks they are running. In England re tration is a prerequisite for employment internes, and it would be quite understand that hospitals here, if they were properly aw of the situation, would have a registered ma their employ over one who had no protection at

Motion: "THAT the Registrar be requested send letters to all hospitals employing gradu internes, emphasizing the existence of tempo licences, and indicating that prosecution will taken if internes are not licensed, thereby leav it up to the superintendent to inform their grad internes that temporary registration is requir Carried.

(c) Temporary Licences for Locum Tenen

The Registrar advised this question had b discussed by the Registration Committee on 26th, and the Executive Committee on Septem 21st. He presented a letter from the solic stating that "Council has authority to issue tem rary licences and provide for the payment of therefor."

Notice of Motion by Dr. C. H. A. Walton:

"THAT the Council may authorize the issu of Certificate of Licence to qualified physic who are undertaking a Locum Tenens for ano physician. The Licence shall be valid for a pe of three months and shall not be renewable. fee for such licence shall be Ten Dollars ($1 plus the annual fee."

(d) Communication From the International Refugee Organization

As requested at the meeting of the Executive Committee, September 21st, the communication from the I.R.O. was read to the members of Council for information. This communication was also to be forwarded to the Public Relations Committee of the Manitoba Medical Association.

B. Registration Committee

The Committee met on eight occasions since the last annual meeting.

The problem of registration for graduates of Canadian universities presents very little difficulty. Enabling Certificates are sometimes requested by students or graduates of other Canadian schools so that the candidate when he acquires the licensure of the Medical Council of Canada may practise in Manitoba. The greatest difficulty has been the Manitoba requirement of one year's internship. The only other difficulty that arose with regard to Canadian applications for registration was in the case of a graduate from another school who failed some of his Dominion Council examinations and wished a temporary licence so that he could practise while preparing for his supplementals. This was not granted. Applications for Enabling Certificates were received from 10 graduates of American schools. These presented no very great difficulty. In most instances the applications originated from graduates of the College of Medical Evangelists in California. These applicants did not intend to practise medicine in Manitoba, but on obtaining their L.M.C.C. they register in Manitoba and hope by this means to obtain reciprocal registration in the Commonwealth List of the British Medical Register as they plan to undertake medical missionary assignments in the colonies. One graduate of the University of Iceland was granted his Enabling Certificate for the purpose of writing his Dominion Council examinations.

Fourteen Chinese doctors from various Chinese universities were granted Enabling Certificates and the fifteenth application was deferred. All of these applicants proposed after acquiring their L.M.C.C. to register in Manitoba for the purpose of obtaining reciprocal registration on the British Medical Register and thus finally obtain registration in the colony of Hong Kong. None intended to practise in Manitoba. The Committee gave very serious thought to the question of thus assisting Oriental doctors and were of the opinion that the College should continue to do so because these people were victims of the civil war in China and their only hope of escaping Communist domination and of practising their profession was in going to Hong Kong. Their only apparent alternative to registration in Manitoba was to proceed to Great Britain and this course presented very great difficulties to most of them. The evaluation of the training and standing of the various Chinese universities and in particular in relation to the effect on them of the Japanese occupation and later Communist occupation, made the problem of decision difficult. In this connection it is gratifying to record that all the applicants appeared to do well on their Dominion Council examinations.

Applicants for Enabling Certificates were received from seven graduates of European universities. Four were granted and three deferred. These applicants were all classified as displaced persons and the consideration of each application presented very serious problems to your Committee. Some obtained their qualifications from universities whose standing was gravely questioned, because of Nazi-German interference or of Russian interference. In some instances graduates from acceptable schools of high standard and which prior to the war had not suffered any loss of academic standing, had lost their credentials due to the vicissitudes of war. On Sunday afternoon, March 12, your Committee met and interviewed individually all of the applicants at that time. In this way the Committee was able to make a more accurate assessment of the applicants and their documents and felt that it not only gave a more accurate decision but the procedure was very much more fair to the applicant. We felt that this procedure should be carried out in the future.

Registration Certificates were granted to six Oriental, two European, one Icelandic, and two American doctors. Sixteen doctors from the United Kingdom were registered and thirteen Canadians from other Canadian schools. Temporary licences were granted to two doctors from the United Kingdom and one from Canada.

Seven student registrations from Canadian schools other than the University of Manitoba were granted.

The problem of unlicensed physicians in Manitoba continued to cause much concern to your Committee as indeed it did to the Executive Committee of the College. The Registrar has dealt with this matter in his report and it is referred to in the minutes of the meeting of the Council in May this year. Many of these unlicensed physicians serve in the Armed Forces, Federal Civil Service and in the Provincial Civil Service. They, of course, are licensed in the provinces of their origin. In addition several displaced persons are employed as physicians by the Government of Mantioba in Government hospitals. These doctors are not licensed. The Registrar will present the details of this problem to this Council today.

All of which is respectfully submitted.

C. H. A. Walton, M.D.,
Chairman.

Motion: "THAT the report of the Registration Committee be adopted." Carried.

Dr. Williams stated that in connection with applicants from Chinese universities, these physicians have been driven from communist dominated areas. He said a list had been received from the Director of Medical Services, Government of Hong Kong, and the Dean of the University of Hong Kong, giving those colleges which they considered to have satisfactory training of graduates in medicine, with the statement, up to the domination of communist influence only. He said that the communist government was trying to reduce instruction by one-half, and cautioned the Council should be very careful in accepting graduates from these universities unless they had received subsequent education during the years.

C. Education Committee

Your Committee has taken under consideration two matters referred to it by Council. viz (1) A Specialist Register and (2) Basic Licence to practise medicine as suggested by Dr. Bramley-Moore of Alberta.

(1) Specialist Register for Province of Manitoba:

The C.P. & S., and to a lesser extent the M.M.A. and the M.M.S. (which latter has its own roster of physicians) are from time to time called upon by various individuals and organized bodies for information regarding the category of medical men as G.P.s or specialists.

To our knowledge, there is in this Province, no overall list so categorizing doctors and indeed there has never been any formal attempt thus to classify them. In other words, a specialist is more or less self-designated. He may limit his work to one branch of medicine either with or without taking any definite postgraduate degrees, courses, or apprenticeship.

British Columbia, as and after May, 1952, will accept as a specialist only one possessing Certification and/or Fellowship with the Royal College of Canada and until that date only one who possesses a Fellowship in the British Colleges, M.R.C.O.G., or Diploma in an American Board. It might be advisable for this Council to consider the adoption of similar regulations for this Province.

Not withstanding the absence at present of an official roster of specialists, we deem it reasonable and useful for our Registrar, with assistance, to draw up a provisional list containing the names of all those who are known definitely to be limiting their practice to a specialty, and who have taken postgraduate training of an adequate nature beforehand or possess the above qualifications outlined already for British Columbia. (Section 38 of our Act entitles the C.P. & S. to place any higher degree or degrees after the name of a person on the Register).

(2) Basic Licence:

This matter was suggested by Dr. Bram Moore, Registrar of the Alberta C.P. & S., in summer of 1949. In June of that year the was presented at a meeting of the President Registrars in Saskatoon. So far as we know special action was taken by them. The su was again brought up at the meeting of Me Council of Canada in Ottawa and no action t It was then decided by the Dean of Medicine L. G. Bell, to appoint a small joint committe study the Basic Licence. No meeting of su committee has been called. In August, 1950 Alberta C.P. & S. Council discussed the co and approved a resolution recommending fu study.

Under Section 66 of our Act it is laid down "Every person registered under the Provisio this Act shall be entitled according to his quali tion or qualifications to practise medicine, su midwifery or any of them, as the case may b the Province of Manitoba, and to demand recover in any court of law, etc., etc."

Thus, under Section 66, any M.D. registere Manitoba is entitled by law to practise any o branches of medicine, surgery and obstetrics w out restriction. The Basic Licence concept w limit the graduate to certain procedures and sponsibilities beyond which he could not go.

In our opinion such a licensure is not fea at this time in our Province:

(a) Because it is incompatible with our Act.
(b) It may be theoretically desirable, but p tically would be tremendously difficul implement and administer.

Therefore we suggest to Council filing of correspondence.

All of which is respectfully submitted.

Brian D. Best, M.D
Chairm

Motion: "THAT the report of the Educa Committee be adopted.." Carried.

The Council considered it would be an ad tage to have one specialist list applicable to whole Province, rather than having separate of the M.M.S., W.C.B., D.V.A., etc.

Motion: "THAT the Legislative Committe requested to prepare a by-law for the purpos setting up a specialist register." Carried.

Motion: "THAT the correspondence concern Basic Licence be filed." Carried.

D. Finance Committee

Motion: "THAT fully registered Dominion Canada 3% bonds to a total of $500.00 be purcha as surplus funds in the Gordon Bell Memorial b balance are deemed sufficient." Carried.

Moton: "THAT fully registered Dominion Canada 3% bonds be purchased for Investm Trust Account from surplus bank balance in

Current Account as deemed advisable by the Finance Committee." Carried.

Dr. Williams inquired whether the Council considered it wise to take any action concerning the question of a permanent home for the C.P. & S. and other medical groups in the city. The matter was postponed to be discussed privately and in groups to see if any concrete suggestions might be made.

E. Legislative Committee

Dr. Poole reported that the Legislative Committee had taken up the matter of membership of the Council, a vote on which had been in favour of leaving the number of members of Council as it is. The second matter discussed by the Committee was the different constituencies represented by the members. According to the Medical Act they are very involved and depend on the federal constituencies at a certain time. The Committee thought it would be advisable to have them changed to medical constituencies which would not be effected by matters political. This would require a change in the Act.

Motion: "THAT the report of the Legislative Committee be accepted." Carried.

Dr. Poole suggested the Council should have the power to change the different constituencies as considered necessary, but must have the support of the College of Physicians and Surgeons.

Motion: "THAT the Legislative Committee prepare a change in the Medical Act giving the Council power to fix the boundaries of the medical constituencies." Carried.

F. Library Committee

Dr. Brian D. Best presented the following statistics as prepared by Miss Ruth D. Monk, Medical Librarian:

Statistics, 1949-50

Contents of Library:

Books, Bound and Unbound Serials (Periodicals): The approximate number of volumes in the Library, exclusive of the duplicate files of serials:

1949-50	1948-49	Progress
17,327 volumes	16,757 volumes	570 volumes

Increase in total number of volumes, 3.40%.

Serials (Periodicals). Titles currently received:

	1949-50	1948-49	Progress
Titles	327	314	
Duplicates	5	6	
	332	320	Increase of 12 Titles

Volumes Added to the Library by the College of Physicians and Surgeons' grant—137 volumes. A decrease of 14 volumes or 9.21% from 1948-49; or 33.41% of all purchases and 24.35% of the total 570 accessions.

Circulation Statistics—Borrowers and Loans

Borrowers, Physicians, City and Medical Faculty (Winnipeg and Suburbs): Number of registered physicians, 530; Individual borrowers, 257, or Percentage of number registered, 48.71%; Increase of individual borrowers, 11.

Total Items Loaned—Books and Journals: 5,213 or 39.98% of all loans, (13,039), an increase of 1,635 items or 45.70% increase over 1948-49.

Borrowers, Physicians, Rural Manitoba: Number of registered physicians, 200; Individual borrowers, 31, or Percentage of number registered, 15.5%; Number of individual borrowers, no change.

Total Items Loaned—Books and Journals: 239, decrease of 2 items.

Registered Physicians, Winnipeg: Medical Faculty, 165; Non-faculty, 365. Total Registered Physicians, 530. Faculty among above borrowing, 101, or 19.06%; Non-faculty among above borrowing, 275, or 52.89%, of the 530 registered physicians.

September 22, 1950.

Motion: "THAT the report of the Library Committee be adopted." Carried.

Re Grant to Medical Library Committee

A communication was read from the Chairman, Medical Library Committee, requesting the usual grant.

Motion: "THAT the College of Physicians and Surgeons of Manitoba grant to the Medical Library Committee, the sum of Seven Hundred and Fifty Dollars ($750.00) for the year 1950-51, to be paid from the Investment Trust Account." Carried.

G. Taxing Committee

No report.

H. Discipline Committee

In the absence of the Chairman of the Discipline Committee, the Registrar reported a meeting had been held in the morning.

Re Dr. .....

The Executive Committee on September 21st recommended that a communication should be addressed to the Workmen's Compensation Board, advising that if the Board was having difficulty with Dr. ....., they should notify him that his name would be deleted from the list of physicians able to deal with the W.C.B. cases. This suggestion was endorsed by the Discipline Committee.

Motion: "THAT the Council accepts the recommendation of the Discipline Committee concerning Dr. ....." Carried.

Re Disciplinary By-law

The Registrar reported the solicitor had met with the Discipline Committee. The proposed by-law as outlined at the May Council meeting had been forwarded to the solicitor who prepared a draft which was submitted to the Executive Committee on Sept. 21. The solicitor advised that with

some rewording of the draft copy, it would be within the limits allowed by the Medical Act. The Committee suggested that the by-law be approved in principle, that any necessary minor adjustments be made by the solicitor, and final approval be given by the Executive before inclusion in the By-laws. The suggestions of the solicitor made no marked change in the proposed by-law, but clarified the procedure presented to Council in May.

Motion: "THAT the suggestion of the Discipline Committee re proposed Discipline By-law be adopted." Carried.

Motion: "THAT the report of the Discipline Committee be accepted." Carried.

5. Reports of Special Committees and Their Consideration

A. Representatives to the Manitoba Medical Association Executive

Dr. Stewart stated there was nothing special to report from the meetings of the M.M.A. Executive.

Request for Grant for Extra Mural Postgraduate Work

A communication was read from the Manitoba Medical Association, requesting the usual grant for extra mural postgraduate work.

Motion: "THAT the College of Physicians and Surgeons of Manitoba grant to the Manitoba Medical Association a sum up to Five Hundred Dollars ($500.00) for the season 1950-51, for extra mural postgraduate work, to be paid from the Investment Trust Account." Carried.

Resquest for Grant for Fee Assessment Commitee, Workmen's Compensation Board

A communication was read from the Manitoba Medical Association, requesting the grant for payment of the Fee Assessment Committee, Workmen's Compensation Board.

Motion: "THAT the College of Physicians and Surgeons of Manitoba grant to the Manitoba Medical Association a sum up to One Hundred and Eighty Dollars ($180.00) for the season 1950-51, for payment of the Fee Assessment Committee, Workmen's Compensation Board." Carried.

B. Trustees of the Gordon Bell Memorial Fund

A recommendation of the Trustees of the Gordon Bell Memorial Fund was presented, stating they had agreed that a scholarship be awarded to Ashley Edwin Thomson, B.A., M.D., M.Sc., at present working in the Research Unit of the Department of Medicine of the University of Manchester. A summary of Dr. Thomson's work was enclosed.

Motion: "THAT the report of the Trustees of the Gordon Bell Memorial Fund be accepted." Carried.

Motion: "THAT the sum of One Thousand Dollars ($1,000.00) be paid to Dr. Ashley Edwin Thomson from the Gordon Bell Memorial Fund." Carried.

C. Representatives to the Committee of Fifteen

No meeting.

D. Representative to the Committee on Admissions

Dr. Williams presented the following report.

There have been no further developments since my report in May last. The decision has been made that for selection to enter Medical College next year there shall be a much wider appraisement of the student in addition to examination averages. A panel of interviewers is being set up for this purpose and your representative confidently expects improvement of the unsatisfactory conditions which have existed.

Motion: "THAT the report of the Representative to the Committee on Admissions be adopted." Carried.

E. Representatives to the Medical Council of Canada

Dr. J. S. Poole presented the following report.

The Medical Council of Canada met in Ottawa for a two-day session, 13th and 14th of September.

My colleague, Dr. Brian Best, was unavoidably absent; two members had died a few days before the meeting.

The report of the Registrar showed that there were now 11,700 licentiates of the Council. 200 were granted this year. All but one were by examination.

The Committee on Enabling Certificates has apparently passed into the limbo of forgotten things—it was not even mentioned.

As usual the Committee on Education had the major share of the work. Ontario and Quebec register only those with Canadian citizenship. The legal advisor of the Council, who was present at the meeting, was not sure of the legality of this procedure, but would forward a written report in a few days.

Toronto University submitted a brief asking that only men engaged in teaching should be appointed as examiners; secondly that the examination papers should first be submitted to the Faculties of Medical Schools. Both these suggestions were rejected. The scheme of having a general Practitioner's degree and other for Specialists was dismissed with the suggestion that these questions were not within the ambit of the Council's powers but were matters for Provincial Licensing Bodies and for the Canadian Medical Association.

A request for an examination in Psychiatry was rejected. It was felt that if this were granted there would be requests of a similar nature

Dermatology, Pediatrics, and a host of other specialties. Another that the examination in Bacteriology and Pathology be discontinued was laid over and delegates were asked to bring the opinion of their parent bodies to next year's meeting.

The opinion was expressed that the interne year should be postgraduate, but Manitoba and Dalhousie objected claiming that the undergraduate year was quite satisfactory. The question was not decided.

The main board of examiners claimed that the work was too heavy and two extra men were added to each division.

Motion: "THAT the report of the Representatives to the Medical Council of Canada be adopted." Carried.

F. Representative to the University Senate

Dr. C. H. A. Walton presented the following report:

Your representative attended all meetings of the Senate of the University of Manitoba held since October, 1949. Since my interval report of last May there has been but one meeting of the Senate which could not be attended because of the concurrent meeting of the Manitoba Medical Association.

As a member of the Senate I serve on the Committee for Nursing Education. A report of this committee's activities was contained in my interim report of last May. The Registrar will report to you a reply received from the Minister of Health and Public Welfare on the resolution passed by this Council.

As previously reported I also serve on the Basic Sciences Committee and I would refer you to the minutes of the meeting of the Council of last May. It is a fortunate circumstance that the Chairman of your Registration Committee should also have the privilege of being a member of the Senate Committee on Basic Sciences because in the Basic Sciences Committee he has an opportunity of becoming familiar with many problems relating to the basic training of applicants for enabling certificates to the College. Most of the problems which come up to the Registration Committee have previously come to my notice on the Basic Sciences Committee .

Motion: "THAT the report of the representative of the University Senate be adopted." Carried.

G. Representative to the Cancer Institute

Dr. Macfarland presented copies of the four-way agreement as published in the Manitoba Medical Association Committee Reports, Sections 47 to 60. He stated he had attended one meeting of the Medical Advisory Committee, at which time the wording of a draft press release concerning the new service, and a draft of a form to be used by the doctor in referring a patient to the service, was submitted.

Motion: "THAT the report of the representative to the Cancer Institute be adopted." Carried.

H. Representatives to the Liaison Committee M.M.A. & C.P. & S.

No meeting.

I. Representative to the Canadian Arthritis and Rheumatism Society—Manitoba Division

Dr. Macfarland advised there was nothing further to report since the meeting of the Executive Committee, September 21st.

6. Election of Officers and Standing Committees

Officers

President: "THAT Dr. I. Pearlman be appointed President." Carried.

Vice-President: "THAT Dr. F. K. Purdie be appointed Vice-President." Carried.

Registrar: "THAT Dr. M. T. Macfarland be appointed Registrar." Carried.

Treasurer: "THAT Dr. T. H. Williams be appointed Treasurer." Carried.

Nomination Committee to Strike Standing Committees

Motion: "THAT Doctors J. S. Poole, C. E. Corrigan and C. B. Stewart be appointed a committee to strike Standing Committees." Carried.

Dr. Edward Johnson vacated the Chair, in favour of the newly elected President, Dr. I Pearlman.

Standing Committees

Registration Committee: Dr. C. H. A. Walton, Chairman; Dr. C. E. Corrigan, Dr. W. J. Boyd.

Education Committee: Dr. B. D. Best, Chairman; Dr. A. L. Paine, Dr. W. J. Boyd.

Finance Committee: Dr. T. H. Williams, Chairman; Dr. C. S. Crawford, Dr. B. Dyma.

Legislative Committee: Dr. J. S. Poole, Chairman; Dr. A. L. Paine, Dr. F. K. Purdie, Dr. T. W. Shaw, Dr. C. W. Wiebe.

Discipline Committee: Dr. C. W. Wiebe, Chairman; Dr. G. P. Armstrong, Dr. C. E. Corrigan, Dr. Wm. Malyska, Dr. H. Guyot.

Executive Committee: Dr. C. B. Stewart, Chairman; Dr. J. S. Poole, Dr. Edward Johnson, Dr. C. H. A. Walton, Dr. B. D. Best.

Library Committee: Dr. Edward Johnson.

Taxing Committee: Dr. C. W. Wiebe, Chairman; Dr. B. Dyma, Dr. C. B. Stewart.

Motion: "THAT the appointment of Standing Committees be accepted." Carried.

Election of Special Committees

Representatives to the Manitoba Medical Association Executive: "THAT our representatives to the Manitoba Medical Association Executive be Dr. C. B. Stewart and Dr. Edward Johnson." Carried.

Representatives to the Committee of Fifteen: "THAT our representatives to the Committee of Fifteen be Dr. B. D. Best, Dr. I. Pearlman and Dr. Edward Johnson." Carried.

Representative to the Committee of Selection in Medicine: "THAT our representative to the Committee of Selection in Medicine be Dr. T. H. Williams." Carried.

Representatives to the Medical Council of Canada: The Registrar explained that Dr. J. S. Poole and Dr. B. D. Best had been appointed as our representatives to the Medical Council of Canada in 1948 for a term of four years. A letter was presented from Dr. Best stating that owing to pressure of work he had found it impossible to attend the last two meetings, and wished to tender his resignation as representative to the Medical Council of Canada.

Motion: "THAT Dr. B. D. Best's resignation as our representative to the Medical Council of Canada be accepted. Carried.

Motion: "THAT in the event the Medical Council of Canada accepts Dr. B. D. Best's resignation as representative from the College of Physicians and Surgeons of Manitoba, Dr. C. E. Corrigan be appointed in his place." Carried.

Representative to the University Senate: "THAT our representative to the University Senate be Dr. C. H. A. Walton." Carried.

Representatives to the Liaison Committee—M.M.A. & C.P. & S.: "THAT our representatives to the Liaison Committee—M.M.A. & C.P. & S., be Dr. B. D. Best, Dr. Edward Johnson and Dr. I. Pearlman." Carried.

Representative to the Canadian Arthritis and Rheumatism Society, Manitoba Division: "THAT our representative to the Medical Advisory Committee, Canadian Arthritis and Rheumatism Society, Manitoba Division, be Dr. M. T. Macfarland." Carried.

Appointment of Auditors and Scrutineers: "THAT the appointment of auditors be deferred until the May meeting of Council." Carried.

The Registrar explained that the scrutineers had been appointed in 1949 for the term of the Council.

7. Reading of Communications, Petitions, Etc., to the Council

Reinstatement of Dr. .....

A letter requesting reinstatement, together with several letters of recommendation, and Certificate of Credit under the Basic Sciences Act, were presented from Dr. ..... Dr. ..... was discharged from the Hospital for Mental Diseases, Selkirk, for a probationary period of six months, on July 10, 1950.

Motion: "THAT action on Dr. .....'s application for reinstatement be deferred." Carried.

Communication From the Canadian Red C Blood Transfusion Service:

A request was read from the Assistant Nati Director, Canadian Red Cross Blood Transfu Service, Toronto, that fully qualified and re tered nurses with special training in venepunc technique under Red Cross Medical Officers, permitted to do the bleeding with or wit medical supervision.

Motion: "THAT fully qualified nurses be mitted to do the bleeding for the Red Cross B Transfusion Service, under the supervision medical personnel." Carried.

Erasure of Dr. ..... From Register, C.P. & Sask.

A communication was presented from Registrar, C.P. & S., Saskatchewan, advis that Dr. .....'s name was ordered erased f the Saskatchewan Medical Register, by orde the Council following a report by the Discipl Committee. Dr. Macfarland advised Dr. ..... registered with the C.P. & S., Manitoba, on 26, 1919.

Motion: "THAT the correspondence with College of Physicians and Surgeons of Saskat wan concerning the erasure of Dr. ..... referred to the Discipline Committee." Carri

8. Enquiries

None.

9. Notice of Motion

(a) Notice of Motion by Dr. C. H. A. Walto

"THAT members of His Majesty's perma forces stationed in Manitoba, and full time e ployees in the public service of Canada statio in Manitoba, be accepted for temporary lice with the College of Physicians and Surgeons Manitoba, provided they are registered and in g standing with one Province of Canada, upon p ment of the annual fee."

(b) Notice of Motion by Dr. C. H. A. Walto

"THAT the Council may authorize the issua of Certificate of Licence to qualified physici who are undertaking a Locum Tenens for anot physician. The Licence shall be valid for a per of three months and shall not be renewable. T fee for such Licence shall be Ten Dollars ($10. plus the annual fee."

10. Motions of Which Notice Was Given at a Previous Meeting

The following Notice of Motion was given Dr. T. H. Williams at the May meeting of Coun

"THAT the revised By-laws, Rules and Re lations be accepted as printed, with power to ma any minor changes which may be suggested."

Dr. Edward Johnson advised that seve changes had been suggested at the Executive Co mittee meeting on September 21st, and said t the following minor changes had been sugges

Election By-law, Paragraph 1 (0)—that the words "at the hour of Eight o'clock p.m., be deleted, and the paragraph changed to read " . . . calling the meeting of the Council, on the Third Wednesday of October, at the hour the Executive Committee may decide . . ."

Committee on Finance, Paragraph 31—that the word "Three" be deleted after the phrase "which shall consist of," and the phrase "the Treasurer and two" be inserted.

Dr. Johnson advised these changes had been approved by the legal advisor.

Motion: "THAT the By-laws, Rules and Regulations be accepted as amended." Carried.

11. Unfinished Business

None.

12. Miscellaneous and New Business

(a) Payment of Janitor.

Motion: "THAT the amount paid to the janitor for his services be Five Dollars ($5.00) plus the costs of refreshments." Carried.

(b) Amount to be Paid to Council Members for This Meeting

Motion: "THAT the amounts paid to members of Council for attendance at this meeting be the same as for the May meeting." Carried.

(c) Motion Re Salaries and Amount to be Paid to the M.M.A. Each Month

Motion: "THAT the salary of the Registrar be Two Hundred Dollars ($200.00) per month, the Treasurer be Five Hundred Dollars ($500.00) per year, that the Manitoba Medical Association be paid Two Hundred Dollars ($200.00) per month for office and secretarial expenses, and that the question of the amount paid to the Manitoba Medical Association be referred to the Liaison Committee and if they propose any change, the Executive Committee be empowered to take action accordingly." Carried.

(d) Adjournment

Motion: "THAT the meeting be adjourned." Carried.

R. J. BAKER

R. A. PULS

F. A. LEWIS

Mr. Fraser Sweatman, General Manager, announces the following staff changes and appointments in the Fisher & Burpe Limited organization:

Mr. Baker, formerly with the Sales Department in the Winnipeg office, has been appointed Sales Representative for Manitoba and North West Ontario.

Mr. Puls is well known in Winnipeg, having represented Fisher & Burpe for a number of years. He now also serves as Technical Consultant for the Winnipeg office.

Mr. Lewis, prior to his appointment as Merchandising Manager in the Winnipeg office, was Sales Representative for Manitoba and North West Ontario.

MEDICAL LIBRARY

The University of Manitoba, Faculty of Medicine

Recent Accessions

The Medical Library will prepay all postage charges on Rural Manitoba Loans. There is therefore no charge to the Borrower either when the Loans are sent or returned.

General List

Lewis, Sir Thomas. Electrocardiography and clinical disorders of the heart beat.
Shaw, 1949. 285 p.

Lichtman, S. S. Diseases of the liver, gall bladder and bile ducts. 2nd ed.
Lea and Febiger, 1949. 1131 p.

Lyle, T. K. and Jackson, Sylvia. Practical orthoptics in the treatment of squint.
Lewis, 1949.

McDougall, J. B. Tuberculosis; a global study in social pathology.
Livingstone, 1949. 455 p.

McLaren, J. W. Modern trends in diagnostic radiology.
Butterworth, 1948.

McLester, J. S. Nutrition and diet in health and disease. 5th ed.
Saunders, 1949. 800 p.

Marshall, M. S. Applied medical bacteriology.
Lea and Febiger, 1947. 340 p.

Meakins, J. C. Symptoms in diagnosis. 2nd ed.
Williams, 1948. 542 p.

Means, J. H. The thyroid and its diseases. 2nd ed.
Lippincott, 1948. 571 p.

Medvei, V. C. The mental and physical effects of pain.
Livingstone, 1949. 59 p.

Meleney, F. L. Clinical aspects and treatment of surgical infections.
Saunders, 1949. 840 p.

Mettler, C. C. History of medicine.
Blakiston, 1947. 1215 p.

Miller, W. S. The lung. 2nd ed.
Thomas, 1947. 222 p.

Millin, T. J. Retropubic urinary surgery.
Livingstone, 1947.

Moore, C. R. Embryonic sex hormones and sexual differentiation.
Thomas, 1947. 81 p.

Mottram, V. H. Human nutrition.
Arnold, 1948. 151 p.

Murphy, F. D. Acute medical disorders; diagnosis and treatment.
Davis, 1949. 567 p.

Newton, W. H. Recent advances in physiology. 7th ed.
Churchill, 1949. 268 p.

New York Academy of Medicine. Institute social medicine. Social medicine; its definitions and objectives, ed. by Iago Galdston.
Commonwealth, 1949. 294 p.

New York Academy of Sciences. Allergy, by Coca.
The Academy, 1949.

New York Academy of Sciences. Aureomycin, B. M. Duggar.
The Academy, 1948.

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The Academy, 1947.

New York Academy of Sciences. The chemotherapy of tuberculosis; the experimental approach, G. Rake.
The Academy, 1949.

New York Academy of Sciences. The Golgi apparatus; an interpretation of its structure and significance, by L. G. Worley.
The Academy, 1946.

New York Academy of Sciences. Hemorrhage, Gregory Shwartzman.
The Academy, 1948.

New York Academy of Sciences. Newer synthetic analgesics, by M. L. Tainter.
The Academy, 1948.

New York Academy of Sciences. Nutrition in relation to cancer, by C. G. King.
The Academy, 1947.

New York Academy of Sciences. Poly-electrolytes, by J. A. Wheeler.
The Academy, 1946.

New York Academy of Sciences. Recent studies in the mechanisms of embryonic development, E. J. Boell.
The Academy, 1948.

New York Academy of Sciences. Surface active agents, by M. L. Anson.
The Academy, 1946.

New York Academy of Sciences. Symposium. Effects of derivatives of folic acid on certain types of neoplastic disease.
The Academy, 1948.

New York Academy of Sciences. Teleological mechanisms, by N. K. Frank.
The Academy, 1948.

New York Academy of Sciences. Thyroid function as disclosed by newer methods of study, by J. Means.
The Academy, 1949.

Ogilvie, Sir William H. Surgery, orthodox and heterodox.
Blackwell Scientific Publications, 1948. 24

Olmsted, J. M. D. Francois Magendie, pioneer in experimental physiology and scientific medicine in XIX century France.
Schumans, 1944.

Page, I. H. and Corcoran, A. C. Arterial hypertension; its diagnosis and treatment. 2nd ed.
Year Book Publishers, 1949. 400 p.

Paterson, Donald and Moncrieff, Alan. Diseases of children.
Arnold, 1949.

Ponder, E. H. Hemolysis and related phenomena.
Grune and Stratton, 1948. 398 p.

Potter, E. L. and Adair, F. L. Fetal and neonatal death; a survey of the incidence, etiology, and anatomic manifestations of the conditions producing death of the fetus in utero and the infant in the early days of life. 2nd ed.
University of Chicago Press, 1949. 173 p.

Pratt, G. H. Surgical management of vascular diseases.
Lea and Febiger, 1949. 496 p.

Pratt, J. H. A year with Osler, 1896-1897.
Johns Hopkins Press, 1949.

Proceedings of the first clinical ACTH conference.
Blakiston, 1950.

Rees, J. R., ed. Modern practice in psychological medicine, 1949.
Butterworth, 1949. 475 p.

Rhodes, A. J. and Van Rooyen, C. E. Textbook of virology for students and practitioners of medicine.
Nelson, 1949. 312 p.

Ricci, J. V. Diagnosis in gynaecology; a classification of gynaecological diseases based on aetiology and the clinical logic for diagnosis.
Blakiston, 1948. 259 p.

Robertson, J. K. Radiology physics. 2nd ed.
Van Nostrand, 1948. 323 p.

Robinson, Judith. Tom Cullen of Baltimore.
Oxford University Press, 1949. 435 p.

Robinson, W. J. Practical prevenception.
American Biological Society, 1929. 170 p.

Ronchese, Francesco. Occupational marks and other physical signs. Grune, 1948. 181 p.

Ross, Ishbel. (Elizabeth Blackwell) Child of destiny; the life story of the first woman doctor.
Harper, 1949. 309 p.

Ross, T. A. The common neuroses; their treatment by psychotherapy. 2nd ed.
Arnold, 1937. 236 p.

Rowbotham, G. F. Acute injuries of the head, their diagnosis, treatment complications and sequels. 3rd ed.

Royal College of Physicians of London. The nomenclature of disease. 7th ed.
H. M. Stationery Off., 1948. 385 p.

Rusk, H. A. and Taylor, E. J. New hope for the handicapped.
Harper, 1949. 213 p.

Russell, D. S. Observations on the patholog hydrocephalus.
H. M. Stationery Off., 1949. 138 p.

Rynearson, E. H. and Gastineau, C. F. Obesit Thomas, 1949. 134 p.

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Reinhold, 1948. 286 p.

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Cornell University Press, 1945. 255 p.

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Lippincott, 1948. 255 p.

Smith, Rodney. Acute intestinal obstruction; a chapter on radiological diagnosis.
Arnold, 1948. 259 p.

Snyder, F. F. Obstetric analgesia and anaesth their effects upon labor and the child.
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Spaeth, E. B. Principles and practice of opht mic surgery. 4th ed.
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Stefansson, V. Not by bread alone.
Macmillan, 1946. 339 p.

Stephenson, Marjory. Bacterial metabolism. 3rd
Longmans, 1949. 398 p.

Stevenson, R. S. Recent advances in oto-lar gology. 2nd ed.
Churchill, 1949.

Stieglitz, E. J. Geriatric medicine. 2nd ed.
Saunders, 1949. 773 p.

Sulzberger, M. B. and Wolf, Jack. Dermatol therapy in general practice. 3rd ed. rev.
The Year Book Publishers, 1948. 663 p.

Sutton, R. L. and Sutton, R. L., jr. Handbook diseases of the skin.
Mosby, 1949. 749 p.

Thompson, Morton. The cry and the covenant
Doubleday, 1949.

Thomson, Sir St. Clair, and Negus, V. E. Dise of the nose and throat. 5th ed.
Cassell, 1948. 1004 p.

Thomson-Walker, Sir John. Genito-urinary s ery.
Cassell, 1948.

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